

AMENDED IN SENATE JANUARY 16, 2008

AMENDED IN ASSEMBLY DECEMBER 17, 2007

AMENDED IN ASSEMBLY DECEMBER 13, 2007

AMENDED IN ASSEMBLY NOVEMBER 8, 2007

CALIFORNIA LEGISLATURE—2007–08 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL

No. 1

Introduced by Assembly Member Nunez
(Principal coauthor: Senator Perata)

September 11, 2007

An act to amend Section 2069 of, to add Sections 4040.1, 4071.2, 4071.3, and 4071.4 to, and to add and repeal Section 2838 of, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.2, 12803.25, 22830.5, and 22830.6 to, and to add Chapter 15 (commencing with Section 8899.50) to Division 1 of Title 2 of, the Government Code, to amend Sections 1357.54, 1365, 124900, 124905, 124910, 124920, 128745, and 128748 of, to amend, repeal, and add Section 1399.56 of, to add Sections 1262.9, 1342.9, 1347, 1356.2, 1367.16, 1367.205, 1367.38, 1368.025, 1378.1, 1395.2, 1399.58, 104376, 124905.1, 124946, and 130545 to, to add Chapter 1.6 (commencing with Section 155) to Part 1 of Division 1 of, to add Article 11.6 (commencing with Section 1399.820) to Chapter 2.2 of Division 2 of, to add Article 1 (commencing with Section 104250) to Chapter 4 of Part 1 of Division 103 of, to add Article 3 (commencing with Section 104705) to Chapter 2 of Part 3 of Division 103 of, and to add Chapter 4 (commencing with Section 128850) to Part 5 of Division 107 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, and 12693.76 of, to amend, repeal, and add Section 796.02 of, to add Sections 796.05, 10113.10, 10113.11, 10123.56, 10176.15,

10273.6, 12693.56, 12693.57, 12693.58, 12693.59, 12693.766, 12886, and 12887 to, to add Chapter 9.6 (commencing with Section 10919) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) and Part 6.7 (commencing with Section 12739.50) to Division 2 of, the Insurance Code, to add Section 96.8 to the Labor Code, to amend Sections 19167 and 19611 of, to add Sections 17052.31, 17052.32, 19528.5, and 19553.5 to, and to add and repeal Section 17052.30 of, the Revenue and Taxation Code, to add Sections 301.1 and 1120 to, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 12306.1, 14005.30, and 14011.16 of, to add Sections 14005.301, 14005.305, 14005.306, 14005.310, 14005.311, 14005.331, 14005.333, 14011.16.1, 14074.5, 14081.6, 14092.5, 14132.105, and 14137.10 to, and to add Article 5.215 (commencing with Section 14167.22) to, and to add and repeal Article 5.21 (commencing with Section 14167.1) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1, as amended, Nunez. Health care reform.

(1) Existing law creates the California Health and Human Services Agency.

This bill would require the agency, in consultation with the Board of Administration of the Public Employees' Retirement System (PERS), to assume lead agency responsibility for professional review and development of best practice standards for high-cost chronic diseases that state health care programs would be required to implement upon their adoption. The bill would additionally require the agency, in consultation with PERS and health care provider groups, to develop health care provider performance measurement benchmarks, as specified.

The bill, effective July 1, 2008, would create the California Health Care Cost and Quality Transparency Committee in the California Health and Human Services Agency, with various powers and duties, including the development and periodic review of a health care cost and quality transparency plan. The bill would require the Office of Statewide Health Planning and Development to assist the committee in that regard. The bill would require the Secretary of California Health and Human Services to track and assess the effects of health care reform and to

report to the Legislature by March 1, 2012, and biennially thereafter. The bill would also create the California Health Benefits Service within the State Department of Health Care Services, with various powers and duties relative to creation of joint ventures between certain county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans and would create a stakeholder committee.

(2) Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services and county welfare departments.

This bill would require California residents, subject to certain exceptions, to enroll in and maintain at least minimum creditable health care coverage, as determined by the Managed Risk Medical Insurance Board, for themselves and their dependents, as defined. The bill would require the board to establish, by regulation, the definition and standards for minimum creditable coverage, including an affordability standard and hardship exemptions, by March 1, 2009, and would require the board to facilitate enrollment in public or private coverage and to establish an education and awareness program, by January 1, 2010, relating to the requirement to obtain minimum creditable coverage. The bill would enact related provisions, including authorizing a school district, on and after January 1, 2010, to provide parents and guardians information explaining these health care coverage requirements.

The bill would, as of January 1, 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a statewide purchasing pool for health care coverage and be administered by the Managed Risk Medical Insurance Board. The bill would specify eligibility for Cal-CHIPP and would require the board to develop and offer a variety of benefit plan designs, including the Cal-CHIPP Healthy Families plan in which enrollment would be restricted to specified low-income persons. The bill would authorize

an employer to pay all or a part of the premium payment required of its employees enrolled in Cal-CHIP. The bill would make it an unfair labor practice for an employer to refer an employee, or his or her dependent, to Cal-CHIP or to arrange for their application to that program to separate them from group coverage provided through the employment relationship, and for an employer to change the share-of-cost ratio or modify coverage in order for an employee or his or her dependents to enroll in that program. Because an unfair labor practice may be punishable as a crime, the bill would impose a state-mandated local program. The bill would create the California Health Trust Fund in the State Treasury for the purposes of this act. The bill would require the State Department of Health Care Services to seek any necessary federal approval to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill, on and after July 1, 2010, would also extend Medi-Cal benefits to parents and caretaker relatives and various other persons meeting certain eligibility requirements. The bill would require certain of these individuals to receive their benefits in the form of a benchmark package, which would be the Cal-CHIP Healthy Families benefit package. The bill would provide for the benchmark benefits to be administered by the Managed Risk Medical Insurance Board, pursuant to an interagency agreement with the department. The bill would make these provisions subject to federal financial participation and approval, as specified.

The bill would require the State Department of Health Care Services to establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval. The bill would also require the Director of Health Care Services to establish a local coverage option program for low-income adults that would be the exclusive Medi-Cal coverage for a 4-year period beginning with the program's commencement, for county residents who, among other requirements, have a family income at or below 100% of the federal poverty level and are not otherwise eligible for the Medi-Cal program. The bill would specify that the program would become operational for services rendered on or after July 1, 2010. The bill would specify that coverage under the program would be provided at a county's option and only by a county that operates a designated public hospital, subject to approval by the State Department of Health Care Services and contingent on

establishment of a county share of cost. The bill would require the State Department of Health Care Services, by January 1, 2010, to contract with an independent 3rd party to develop an assessment tool to measure the care provided under the program. The bill would require the department, after 3 years of the program's operation, to evaluate the program using the assessment tool and would extend the program for an additional 2 years if the program substantially met certain criteria and would terminate the program if it did not. The bill would enact other related provisions.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program on and after July 1, 2009. The bill would, on and after July 1, 2009, delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child satisfy citizen and immigration status requirements applicable to the programs under federal law, thereby creating a state-only element of the programs. The bill would additionally, on and after July 1, 2009, disregard all income over 250% but less than or equal to 300% of the federal poverty level and would apply Medi-Cal program income deductions to a family income greater than 300% of the federal poverty level in determining eligibility for the Healthy Families Program. The bill would authorize the board to provide, or arrange for the provision of, an electronic personal health record under the Healthy Families Program, to the extent funds are appropriated for that purpose, and would provide for the confidentiality of information obtained pursuant to the program.

The bill would require the department to exercise its federal option as necessary to simplify Medi-Cal eligibility by exempting all resources for certain applicants and recipients, commencing July 1, 2010.

The bill would enact the Medi-Cal Physician Services Rate Increase Act, which would establish, with respect to services rendered to Medi-Cal beneficiaries on and after July 1, 2010, to the extent funds are appropriated in the annual Budget Act, increased reimbursements of up to 100% of the Medicare rate for physicians, physician groups, as defined, and others that are enrolled Medi-Cal providers eligible to receive payments for Medi-Cal services. The bill would permit some of these rate increases to be linked to specified performance measures and would provide that these rate increases would be implemented only to the extent that state funds are appropriated for the nonfederal share of these increases. The bill would require the Director of Health Care Services to seek federal approval of the rate methodology set forth in

the act and would prohibit the methodology from being implemented if federal approval is not obtained.

Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

This bill would also enact the Medi-Cal Hospital Rate Stabilization Act, which would revise the methodology by which safety net care pool funds are paid to designated public hospitals for providing uncompensated care to the uninsured. The bill would require the State Department of Health Care Services to determine an outpatient base rate and an inpatient base rate, as defined, for various types of hospitals. The bill would also, commencing July 1, 2010, establish specified reimbursement rate methodologies under the Medi-Cal program for hospital services, as defined, that are rendered by designated public hospitals and for managed health care plans, as specified, and would require managed health care plans to expend 100% of moneys received under the increased rates for payments to hospitals for providing services to Medi-Cal patients. The bill would make implementation of certain of these provisions contingent on the establishment of certain requirements under which counties pay a share of cost for persons enrolled in the Medi-Cal program, and would make implementation of all of these provisions contingent on the imposition of a 4% fee on the net patient revenue of general acute care hospitals.

This bill would also require a portion of the nonfederal share of the reimbursement for designated public hospitals be transferred to the Workforce Development Program Fund, which the bill would create in the State Treasury. Moneys in the fund would, upon appropriation, be used exclusively for retraining county hospital and clinic systems' health care workers and be allocated by the Office of Statewide Health Planning and Development.

(3) Existing law provides for the county administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization.

Existing law permits services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium.

Existing law provides that when any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium, the county shall use county only funds for the state and county share of any increase in the program, unless otherwise provided in the Budget Act or appropriated by statute.

Existing law establishes a formula with regard to provider wages or benefits increases negotiated or agreed to by a public authority or nonprofit consortium, and specifies the percentages required to be paid by the state and counties, beginning with the 2000–01 fiscal year, with regard to the nonfederal share of any increases.

This bill would revise the formula for state participation in provider health benefit increases. The bill would also authorize a county employee representative to elect to provide health benefits through a trust fund, as specified.

(4) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would enact various health insurance market reforms, to be operative on specified dates, including requirements for guarantee issue of individual health care service plan contracts and health insurance policies and other requirements relating to individual coverage, modified disclosures, and other related changes. The bill, on and after July 1, 2010, would require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care benefits and not on administrative costs. The bill would allow a health care service plan and a health insurer to provide notices by electronic transmission using specified procedures.

The bill would require a health care service plan providing prescription drug benefits and maintaining a drug formulary to, commencing on or before January 1, 2010, make the most current formularies available electronically to prescribers and pharmacies and would require health care service plans that provide services to certain beneficiaries under a Medi-Cal managed care program to be subject solely to the filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program for designated subjects. The bill would require the department and the State Department of Health Care Services to develop a joint filing and review process for medical quality surveys.

The bill would also require group health care service plan contracts and group health insurance policies offered, amended, or renewed on or after January 1, 2009, to offer to include a Healthy Action Incentives and Rewards Program, as specified. The bill would also authorize an employer to provide health coverage that includes a Healthy Action Incentives and Rewards Program to his or her employees.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(5) The Personal Income Tax Law authorizes various credits against the taxes imposed by that law.

This bill would, for taxable years beginning on or after January 1, 2010, and before January 1, 2015, allow to a qualified taxpayer, as defined, a refundable credit against those taxes in an amount equal to those qualified health care plan premium costs, as defined, that are in excess of 5.5% of a qualified taxpayer's adjusted gross income for the taxable year, except as provided. This bill would, upon appropriation by the Legislature, require that all amounts deposited into the California Health Trust Fund be transferred to the Managed Risk Medical Insurance Board for purposes of advancing the refundable credit and to the Franchise Tax Board for purposes of recovering amounts expended for the refunds, as provided.

(6) Existing law creates the Employment Development Department in the Labor and Workforce Development Agency and vests that department with the duties, purposes, responsibilities, and jurisdiction previously exercised by the State Department of Benefit Payments or the California Health and Human Services Agency with respect to job creation activities.

This bill would require the department to establish data collection and reporting methods and requirements, as specified, to collect and report information related to employer health expenditures on behalf of their employees. The bill would require the department to report on that data to the Managed Risk Medical Insurance Board and the Legislature on an annual basis commencing April 1, 2011, and would authorize the department to adopt regulations to implement these provisions.

(7) Under existing federal law, a cafeteria plan is a written plan through which employees choose among 2 or more benefits consisting of cash and qualified benefits. Existing federal law provides that, except as specified, no amount is included in the gross income of a participant

in a cafeteria plan solely because the participant may choose among the benefits of the plan.

This bill would, beginning January 1, 2010, require an employer to adopt and maintain a cafeteria plan to allow employees to pay premiums for health care coverage to the extent amounts for that coverage are excludable from the gross income of the employee, as specified. The bill would require an employer who fails to establish or maintain a cafeteria plan to pay a penalty of \$100 or \$500 per employee, as specified.

(8) Existing law authorizes the Board of Administration of the Public Employees' Retirement System to contract with carriers offering health benefit plans for coverage for eligible employees and annuitants.

This bill would require the board, on or before January 1, 2010, to provide or arrange for the provision of an electronic personal health record for enrollees receiving health care benefits.

(9) Existing law establishes the State Department of Public Health, which licenses and regulates health facilities and also administers funds for programs relating to smoking cessation. Under existing law, a noncontracting hospital is required to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee for inpatient poststabilization care, as defined, or prior to transferring the enrollee, if certain conditions apply. Existing law prohibits the hospital from billing the enrollee for poststabilization care if it is required to, and fails to, contact the enrollee's health care service plan. Under existing law, a violation of any of these provisions is punishable as a misdemeanor.

This bill would prohibit a noncontracting hospital, as defined, from billing a covered patient for emergency health care services and poststabilizing care except for applicable copayments and cost shares. By changing the definition of an existing crime, this bill would impose a state-mandated local program.

The bill would also require the department to maintain the California Diabetes Program to provide information and assistance pertaining to the prevention and treatment of diabetes. The bill would also establish the Comprehensive Diabetes Services Program in the State Department of Health Care Services to provide diabetes prevention and management services to certain beneficiaries in the Medi-Cal program, to the extent funding is available for this purpose. The bill would also require the department, in consultation with the Department of Managed Health Care, the State Department of Health Care Services, the Managed Risk

Medical Insurance Board, and the Department of Insurance, to annually identify the 10 largest providers of health care coverage in the state, to ascertain and summarize the smoking cessation benefits provided by those coverage providers, to publish the benefit summary on the department's Internet Web site, to include the benefit summary as part of its preventive health education against tobacco use campaign, and to evaluate any changes in connection with the smoking cessation benefits provided by the coverage providers, as provided. The bill would also require the department, to the extent that funds are available and appropriated for this purpose, to increase the capacity of effective smoking cessation services available from, and expand the awareness of, services available through, the California Smokers' Helpline, as prescribed.

The bill would also create the Community Makeover Grant program that would be administered by the department and would require it to award grants to local health departments in cities and counties, which would serve as the local lead agencies in administering the program, for the purpose of developing new programs or improving existing programs that promote active living and healthy eating. The bill would require the department to issue guidelines and to specify data reporting requirements for local lead agencies to comply with various requirements relating to the administration of the program. The bill would also require the department to develop a sustained media campaign to educate the public about the importance of obesity prevention.

(10) Existing law requires the State Department of Health Care Services to select certain primary care clinics to be reimbursed for delivering medical services, including preventive health care and smoking prevention and cessation health education, to program beneficiaries, based upon specified criteria. Existing law requires that a clinic meet specified requirements in order to receive a reimbursement. Under existing law, a program beneficiary is a person whose income is at or below 200% of the federal poverty level. Existing law requires the department to utilize existing contractual claims processing services to promote efficiency and maximize the use of funds.

This bill would additionally require that, in order receive a reimbursement, a clinic serve as a designated primary care medical home for program beneficiaries, as specified. The bill would also revise the definition of program beneficiary to mean a person whose income is at or below 250% of the poverty level and who either does not have

private or employer-based health care coverage or is not enrolled in or is ineligible for public health care coverage programs. This bill would delete the provision requiring the department to utilize existing contractual claims processing services and instead authorize the department to contract with public and private entities or utilize existing health care service provider enrollment and payment mechanisms in order to perform its duties, as specified. The bill would additionally require that the department maximize the availability of federal funding for services provided pursuant to these provisions. The bill would make related changes.

(11) Existing law provides for the Office of Statewide Health Planning and Development, which has specified powers and duties. Existing law requires the office to publish specified reports.

This bill would require the office to publish risk-adjusted outcome reports for percutaneous coronary interventions, commencing January 1, 2010, and would require the office to establish a clinical data collection program to collect data on percutaneous coronary interventions and establish by regulation the data to be reported by each hospital.

(12) Existing law provides for the certification and regulation of nurses, including nurse practitioners and nurse-midwives, by the Board of Registered Nursing and for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law provides that a medical assistant may administer medication upon the specific authorization and supervision of a licensed physician and surgeon or licensed podiatrist or, in specified clinic settings, upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant.

This bill would remove the requirement that a medical assistant's administration of medication upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant occur in specified clinic settings, and would make related changes.

(13) Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing which is within the Department of Consumer Affairs.

This bill would, until July 1, 2011, create the Task Force on Nurse Practitioner Scope of Practice that would consist of specified members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. The bill would make the task force responsible for developing a recommended scope of practice for nurse practitioners

and would require the task force to report the recommended scope of practice to the Governor and the Legislature on or before June 30, 2009. The bill would require the Director of Consumer Affairs, on or before July 1, 2010, to promulgate regulations that adopt the recommended scope of practice. The bill would require the aforementioned boards to pay the state administrative costs of implementing these provisions.

(14) Existing law, the Pharmacy Law, defines an electronic transmission prescription and sets forth the requirements for those types of prescriptions.

This bill would require electronic prescribing systems to meet specified standards and requirements and would require a prescriber or prescriber's authorized agent to offer patients a written receipt of information transmitted electronically, including the patient's name and the drug prescribed, and would require the State Department of Health Care Services to develop a pilot program to foster the adoption and use of electronic prescribing by health care providers that contract with the Medi-Cal program, as specified. The bill would require every licensed prescriber, or prescriber's authorized agent, or pharmacy operating in California, on or before January 1, 2010, to have the ability to transmit and receive prescriptions by electronic data transmission.

(15) This bill would give the State Department of Health Care Services, in consultation with the Department of Finance, authority to take various actions as necessary to implement the bill, including promoting flexibility of implementation and maximizing federal financial participation. The bill would require the Director of Health Care Services to notify the Chair of the Joint Legislative Budget Committee prior to exercising this flexibility. The bill would declare the intent of the Legislature to implement the bill to harmonize and best effectuate the purposes and intent of the bill.

(16) This bill would declare the Legislature's intent that the act's provisions be financed by contributions from various sources, including payments by acute care hospitals and employers, and by increasing the taxes on cigarettes and other tobacco products.

(17) The bill would make its provisions operative upon the date that the Director of Finance files a finding with the Secretary of State that, among other circumstances, sufficient state resources will exist in the Health Care Trust Fund to implement those provisions. The bill would also require the director to transmit that finding to the Chief Clerk of the Assembly, the Secretary of the Senate, and the chairs of the

appropriate committees of the Legislature at least 90 days prior to implementation of its provisions.

(18) The bill would require that all of its provisions become inoperative, as specified, if any portion of the bill is held to be invalid, as determined by a final judgment of a court of competent jurisdiction.

(19) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. This act shall be known and may be cited as the
2 Health Care Security and Cost Reduction Act.

3 SEC. 2. It is the intent of the Legislature to accomplish the
4 goal of universal health care for all California residents. To
5 accomplish this goal, the Legislature proposes to take all of the
6 following steps:

7 (a) Ensure that all Californians have access to affordable,
8 comprehensive health care.

9 (b) Leverage available federal funds to the greatest extent
10 possible through existing federal programs.

11 (c) Maintain and strengthen the health insurance system and
12 improve availability and affordability of private health care
13 coverage for all purchasers through (1) insurance market reforms;
14 (2) enhanced access to effective primary and preventive services,
15 including management of chronic illnesses; (3) promotion of
16 cost-effective health technologies; and (4) implementation of
17 meaningful, systemwide cost containment strategies.

18 (d) Engage in early and systematic evaluation at each step of
19 the implementation process to identify the impacts on state costs,
20 the costs of coverage, employment and insurance markets, health

1 delivery systems, quality of care, and overall progress in moving
2 toward universal coverage.

3 SEC. 3. Section 2069 of the Business and Professions Code is
4 amended to read:

5 2069. (a) (1) Notwithstanding any other provision of law, a
6 medical assistant may administer medication only by intradermal,
7 subcutaneous, or intramuscular injections and perform skin tests
8 and additional technical supportive services upon the specific
9 authorization and supervision of a licensed physician and surgeon,
10 nurse practitioner, nurse-midwife, physician assistant, or licensed
11 podiatrist.

12 (2) The licensed physician and surgeon may, at his or her
13 discretion, in consultation with the nurse practitioner,
14 nurse-midwife, or physician assistant, provide written instructions
15 to be followed by a medical assistant in the performance of tasks
16 or supportive services. These written instructions may provide that
17 the supervisory function for the medical assistant for these tasks
18 or supportive services may be delegated to the nurse practitioner,
19 nurse-midwife, or physician assistant within the standardized
20 procedures or protocol, and that tasks may be performed when the
21 licensed physician and surgeon is not onsite, so long as the
22 following apply:

23 (A) The nurse practitioner or nurse-midwife is functioning
24 pursuant to standardized procedures, as defined by Section 2725,
25 or protocol. The standardized procedures or protocol shall be
26 developed and approved by the supervising physician and surgeon,
27 the nurse practitioner or nurse-midwife, and the facility
28 administrator or his or her designee.

29 (B) The physician assistant is functioning pursuant to regulated
30 services defined in Section 3502 and is approved to do so by the
31 supervising physician or surgeon.

32 (b) As used in this section and Sections 2070 and 2071, the
33 following definitions shall apply:

34 (1) "Medical assistant" means a person who may be unlicensed,
35 who performs basic administrative, clerical, and technical
36 supportive services in compliance with this section and Section
37 2070 for a licensed physician and surgeon or a licensed podiatrist,
38 or group thereof, for a medical, nursing, or podiatry corporation,
39 for a physician assistant, a nurse practitioner, or a nurse-midwife
40 as provided in subdivision (a), or for a health care service plan,

1 who is at least 18 years of age, and who has had at least the
2 minimum amount of hours of appropriate training pursuant to
3 standards established by the Division of Licensing. The medical
4 assistant shall be issued a certificate by the training institution or
5 instructor indicating satisfactory completion of the required
6 training. A copy of the certificate shall be retained as a record by
7 each employer of the medical assistant.

8 (2) “Specific authorization” means a specific written order
9 prepared by the licensed physician and surgeon, nurse practitioner,
10 nurse-midwife, physician assistant, or licensed podiatrist
11 authorizing the procedures to be performed on a patient, which
12 shall be placed in the patient’s medical record, or a standing order
13 prepared by the licensed physician and surgeon, nurse practitioner,
14 nurse-midwife, physician assistant, or licensed podiatrist,
15 authorizing the procedures to be performed, the duration of which
16 shall be consistent with accepted medical practice. A notation of
17 the standing order shall be placed on the patient’s medical record.

18 (3) “Supervision” means the supervision of procedures
19 authorized by this section by the following practitioners, within
20 the scope of their respective practices, who shall be physically
21 present in the treatment facility during the performance of those
22 procedures:

23 (A) A licensed physician and surgeon.

24 (B) A licensed podiatrist.

25 (C) A physician assistant, nurse practitioner, or nurse-midwife.

26 (4) “Technical supportive services” means simple routine
27 medical tasks and procedures that may be safely performed by a
28 medical assistant who has limited training and who functions under
29 the supervision of a licensed physician and surgeon, a licensed
30 podiatrist, a physician assistant, a nurse practitioner, or a
31 nurse-midwife.

32 (c) Nothing in this section shall be construed as authorizing the
33 licensure of medical assistants. Nothing in this section shall be
34 construed as authorizing the administration of local anesthetic
35 agents by a medical assistant. Nothing in this section shall be
36 construed as authorizing the division to adopt any regulations that
37 violate the prohibitions on diagnosis or treatment in Section 2052.

38 (d) Notwithstanding any other provision of law, a medical
39 assistant may not be employed for inpatient care in a licensed

1 general acute care hospital as defined in subdivision (a) of Section
2 1250 of the Health and Safety Code.

3 (e) Nothing in this section shall be construed as authorizing a
4 medical assistant to perform any clinical laboratory test or
5 examination for which he or she is not authorized by Chapter 3
6 (commencing with Section 1200). Nothing in this section shall be
7 construed as authorizing a nurse practitioner, nurse-midwife, or
8 physician assistant to be a laboratory director of a clinical
9 laboratory, as those terms are defined in paragraph (7) of
10 subdivision (a) of Section 1206 and subdivision (a) of Section
11 1209.

12 SEC. 5. Section 2838 is added to the Business and Professions
13 Code, to read:

14 2838. (a) The Task Force on Nurse Practitioner Scope of
15 Practice is hereby created and shall consist of the following
16 members:

17 (1) The Director of Consumer Affairs, who shall serve as an ex
18 officio member of the task force and shall cast the deciding vote
19 in any matter voted upon by the task force that results in a tie vote.

20 (2) Three members of the Medical Board of California, two of
21 whom shall be appointed to the task force by the Governor, and
22 one of whom shall be appointed to the task force by the Speaker
23 of the Assembly.

24 (3) Three members of the Board of Registered Nursing, two of
25 whom shall be appointed to the task force by the Governor, and
26 one of whom shall be appointed to the task force by the Senate
27 Committee on Rules.

28 (4) Two representatives of an institution of higher education,
29 who shall be appointed to the task force by the Governor as
30 nonvoting members.

31 (b) The duty of the task force shall be to develop a recommended
32 scope of practice for nurse practitioners.

33 (c) The task force shall report its recommended scope of practice
34 for nurse practitioners to the Governor and the Legislature on or
35 before June 30, 2009.

36 (d) On or before July 1, 2010, the Director of Consumer Affairs
37 shall promulgate regulations *consistent with existing law* that adopt
38 the task force's recommended scope of practice.

1 (e) The Medical Board of California and the Board of Registered
2 Nursing shall pay the state administrative costs of implementing
3 this section.

4 (f) This section shall become inoperative on July 1, 2011, and,
5 as of January 1, 2012, is repealed, unless a later enacted statute,
6 that is enacted before January 1, 2012, deletes or extends the dates
7 on which it becomes inoperative and is repealed.

8 SEC. 7. Section 4040.1 is added to the Business and Professions
9 Code, to read:

10 4040.1. (a) Electronic prescribing shall not interfere with a
11 patient's existing freedom to choose a pharmacy, and shall not
12 interfere with the prescribing decision at the point of care.

13 (b) Notwithstanding subdivision (c) of Section 4040, "electronic
14 prescribing" or "e-prescribing" means a prescription or
15 prescription-related information transmitted between the point of
16 care and the pharmacy using electronic media.

17 SEC. 8. Section 4071.2 is added to the Business and Professions
18 Code, to read:

19 4071.2. (a) On or before January 1, 2012, every licensed
20 prescriber, prescriber's authorized agent, or pharmacy operating
21 in California shall have the ability to transmit and receive
22 prescriptions by electronic data transmission.

23 (b) The Medical Board of California, the State Board of
24 Optometry, the Bureau of Naturopathic Medicine, the Dental Board
25 of California, the Osteopathic Medical Board of California, the
26 Board of Registered Nursing, and the Physician Assistant
27 Committee shall have authority with the California State Board of
28 Pharmacy to ensure compliance with this section, and those boards
29 are specifically charged with the enforcement of this section with
30 respect to their respective licensees.

31 (c) Nothing in this section shall be construed to diminish or
32 modify any requirements or protections provided for in the
33 prescription of controlled substances as otherwise established by
34 this chapter or by the California Uniform Controlled Substances
35 Act (Division 10 (commencing with Section 11000) of the Health
36 and Safety Code).

37 SEC. 9. Section 4071.3 is added to the Business and Professions
38 Code, to read:

39 4071.3. Every electronic prescription system shall meet all of
40 the following requirements:

1 (a) Comply with nationally recognized or certified standards
2 for data exchange or be accredited by a recognized accreditation
3 organization.

4 (b) Allow real-time verification of an individual’s eligibility for
5 benefits and whether the prescribed medication is a covered benefit.

6 (c) Comply with applicable state and federal confidentiality and
7 data security requirements.

8 (d) Comply with applicable state record retention and reporting
9 requirements.

10 SEC. 10. Section 4071.4 is added to the Business and
11 Professions Code, to read:

12 4071.4. A prescriber or prescriber’s authorized agent using an
13 electronic prescription system shall offer patients a written receipt
14 of the information that has been transmitted electronically to the
15 pharmacy. The receipt shall include the patient’s name, the dosage
16 and drug prescribed, the name of the pharmacy where the electronic
17 prescription was sent, and shall indicate that the receipt cannot be
18 used as a duplicate order for the same medicine.

19 SEC. 11. Section 49452.9 is added to the Education Code, to
20 read:

21 49452.9. (a) On and after January 1, 2010, the school district
22 may provide an information sheet regarding health insurance
23 requirements to the parent or guardian of all of the following:

- 24 (1) A pupil enrolled in kindergarten.
- 25 (2) A pupil enrolled in first grade if the pupil was not previously
26 enrolled in kindergarten.
- 27 (3) A pupil enrolled during the course of the year in the case of
28 children who have recently arrived, and intend to remain, in
29 California.

30 (b) The information sheet described in subdivision (a) shall
31 include all of the following:

- 32 (1) An explanation of the health insurance requirements under
33 Section 8899.50 of the Government Code.
- 34 (2) Information on the important relationship between health
35 and learning.
- 36 (3) A toll-free telephone number to request an application for
37 Healthy Families, Medi-Cal, or other government-subsidized health
38 insurance programs.
- 39 (4) Contact information for county public health departments.

1 (5) A statement of privacy applicable under state and federal
2 laws and regulations.

3 (c) By January 1, 2010, the State Department of Education shall,
4 in consultation with the State Department of Health Care Services
5 and the Managed Risk Medical Insurance Board, develop a
6 standardized template for the information sheet required by this
7 section. To the extent possible, the information provided pursuant
8 to this section shall be consolidated with the information listed in
9 subdivision (c) of Section 49452.8 into one document. The State
10 Department of Education shall make the template available on its
11 Internet Web site and shall, upon request, provide written copies
12 of the template to a school district.

13 SEC. 12. Chapter 15 (commencing with Section 8899.50) is
14 added to Division 1 of Title 2 of the Government Code, to read:

15
16 CHAPTER 15. MINIMUM HEALTH CARE COVERAGE

17
18 8899.50. (a) On and after July 1, 2010, every California
19 resident shall be enrolled in and maintain at least minimum
20 creditable coverage, as defined by the Managed Risk Medical
21 Insurance Board pursuant to Section 12739.50 of the Insurance
22 Code, unless otherwise exempt pursuant to subdivision (d).

23 (b) On and after July 1, 2010, a subscriber shall obtain and
24 maintain at least minimum creditable coverage, as defined by the
25 Managed Risk Medical Insurance Board, for any person who
26 qualifies as his or her dependent. For purposes of this chapter, the
27 term “dependent” means the spouse, registered domestic partner,
28 minor child of the subscriber, or a child 18 years of age and over
29 who is dependent on the subscriber, as defined by the Managed
30 Risk Medical Insurance Board.

31 (c) Notwithstanding subdivisions (a) and (b), compliance with
32 those subdivisions shall not be required until Sections 12739.50,
33 12739.51, and 12699.211.01 of the Insurance Code, Section
34 17052.30 of the Revenue and Taxation Code, and Sections
35 14005.301 and 14005.305 of the Welfare and Institutions Code
36 are implemented, and only so long as these sections remain
37 operative, and the Managed Risk Medical Insurance Board has
38 defined by regulation the minimum creditable coverage that will
39 satisfy the requirements of this section.

1 (d) An individual shall not be subject to the requirements of
2 subdivisions (a) and (b) if the Managed Risk Medical Insurance
3 Board, pursuant to Section 12739.501 of the Insurance Code,
4 determines that health care coverage meeting the definition of
5 minimum creditable coverage is not affordable for that individual
6 or that the purchase of minimum creditable coverage would
7 constitute an undue hardship for that individual, or if the person
8 or family has an income at or below 250 percent of the federal
9 poverty level and the person's or family's share of the premium
10 for minimum creditable coverage exceeds 5 percent of his or her
11 family's income.

12 (e) An individual shall not be subject to the requirements of
13 subdivisions (a) and (b) if the individual has been in California for
14 six months or less and is not eligible for guaranteed issue of health
15 care coverage under Section 1399.829 of the Health and Safety
16 Code or Section 10928 of the Insurance Code.

17 (f) "California resident" means an individual who is a resident
18 of the state pursuant to Section 244 or is physically present in the
19 state for at least six months, having entered the state with an
20 employment commitment or to obtain employment, whether or
21 not employed at the time of application for health care coverage
22 or after acceptance.

23 (g) "Subscriber" means an individual with dependents, as
24 determined by the Managed Risk Medical Insurance Board
25 consistent with subdivision (b), who is generally eligible to enroll
26 dependents for health care coverage purposes, including, but not
27 limited to, an individual whose employment status, or status as
28 head of household, parent, spouse, or other status, makes the
29 individual eligible to enroll his or her dependents for health care
30 coverage purposes.

31 *8899.501. For purposes of subdivisions (e) and (f) of Section*
32 *8899.50, subdivision (d) of Section 1399.836 of the Health and*
33 *Safety Code, and subdivision (g) of Section 10928 of the Insurance*
34 *Code, the reference to an individual or person who has been a*
35 *resident of California for six months or less and the definition of*
36 *"California resident" as an individual who is a resident of the*
37 *state for at least six months shall mean a six-month period or any*
38 *lesser period required by federal and state law.*

39 SEC. 13. Section 12803.2 is added to the Government Code,
40 to read:

1 12803.2. The California Health and Human Services Agency,
2 in consultation with the Board of Administration of the Public
3 Employees' Retirement System, and after consultation with
4 affected health care provider groups, shall develop health care
5 provider performance measurement benchmarks and incorporate
6 these benchmarks into a common pay-for-performance model to
7 be offered in every state-administered health care program,
8 including, but not limited to, the Public Employees' Medical and
9 Hospital Care Act, the Healthy Families Program, the Major Risk
10 Medical Insurance Program, the Medi-Cal program, and the
11 California Cooperative Health Insurance Purchasing Program.
12 These benchmarks shall be developed to advance a common
13 statewide framework for health care quality measurement and
14 reporting, including, but not limited to, measures that have been
15 approved by the National Quality Forum (NQF) such as the Health
16 Plan Employer Data and Information Set (HEDIS) and the Joint
17 Commission on Accreditation of Health Care Organizations
18 (JCAHO), and that have been adopted by the Hospitals Quality
19 Alliance and other national and statewide groups concerned with
20 quality. The provisions of Section 14167.25 of the Welfare and
21 Institutions Code shall be implemented in addition to the
22 requirements of this section in such a manner that they are
23 appropriately integrated with the pay-for-performance model
24 required under this section.

25 SEC. 14. Section 12803.25 is added to the Government Code,
26 to read:

27 12803.25. (a) The Secretary of California Health and Human
28 Services, in collaboration with other relevant state agencies, shall
29 track and assess the effects of health care reform as set forth in the
30 act enacting this section. The secretary shall either complete the
31 assessment or contract for its preparation. The secretary may seek
32 other sources of funding, including grants, to fund the assessment.
33 The assessment shall include, at minimum, the following
34 components:

35 (1) An assessment of the sustainability and solvency of the
36 program established pursuant to Part 6.45 (commencing with
37 Section 12699.201) of Division 2 of the Insurance Code. This
38 assessment shall include data regarding persons purchasing health
39 care coverage through that program.

1 (2) An assessment of the cost and affordability of health care
2 in California. This assessment shall include the cost of health care
3 coverage products for individuals and families obtained through
4 employers, city and county governments, the Medi-Cal program,
5 the Healthy Families Program, the Public Employees' Medical
6 and Hospital Care Act, Medicare Advantage plans, and the
7 individual market.

8 (3) An assessment of the health care coverage market in
9 California, including a review of the various insurers and health
10 care service plans, their offerings, their efficiency in providing
11 health care services, and their financial conditions, including their
12 medical loss ratios.

13 (4) An assessment of the effect on employers and employment,
14 including employer administrative costs, employee turnover rate,
15 and wages categorized by the type of employer and the size of the
16 business. The assessment shall also review if there have been
17 significant changes to the labor market and increased underground
18 economy activity.

19 (5) An assessment of the racial and ethnic disparities in access
20 and availability of health care, including cultural competency and
21 language access, and what effects the act adding this section has
22 had in reducing these disparities.

23 (6) An assessment of the change in access and availability of
24 health care coverage throughout the state, including tracking the
25 availability of health care coverage products in rural and other
26 underserved areas of the state and assessing the adequacy of the
27 health care delivery infrastructure to meet the need for health care
28 services. This assessment shall include a more in-depth review of
29 areas of the state that were determined to be medically underserved
30 in 2007.

31 (7) An assessment of the impact on the county health care safety
32 net system, including a review of the amount of uncompensated
33 care and emergency room use.

34 (8) An overall assessment of health care coverage.

35 (9) An assessment of the capacity of the various health care
36 professions and facilities to provide care to Californians.

37 (b) An advisory body of individuals with knowledge and
38 expertise in health care policy and financing shall provide input
39 on the assessment described in subdivision (a). The Governor shall
40 appoint five members to the advisory body, the Senate Committee

1 on Rules shall appoint two members, and the Speaker of the
2 Assembly shall appoint two members.

3 (c) To the extent possible, the assessment described in
4 subdivision (a) shall maximize the use of current surveys and
5 databases.

6 (d) To the extent feasible, in order to track the effect of health
7 care reform on ongoing trends in the health care field, the
8 assessment described in subdivision (a) shall include data from
9 years prior to the enactment of the program established pursuant
10 to Part 6.45 (commencing with Section 12699.201) of Division 2
11 of the Insurance Code.

12 (e) All state agencies shall cooperate with the secretary in
13 implementing the provisions of this section.

14 (f) The Secretary of California Health and Human Services shall
15 submit the assessment described in subdivision (a) to the
16 appropriate policy and fiscal committees of the Legislature on or
17 before March 1, 2012. The secretary shall update the assessment
18 biennially.

19 SEC. 15. Section 22830.5 is added to the Government Code,
20 to read:

21 22830.5. (a) On or before January 1, 2010, the board shall
22 provide or arrange for the provision of an electronic personal health
23 record for enrollees receiving health care benefits. The record shall
24 be provided for the purpose of providing enrollees with information
25 to assist them in understanding their coverage benefits and
26 managing their health care.

27 (b) At a minimum, the personal health record shall provide
28 access to real-time, patient-specific information regarding
29 eligibility for covered benefits and cost sharing requirements. Such
30 access can be provided through the use of an Internet-based system.

31 (c) In addition to the data required pursuant to subdivision (b),
32 the board may determine that the personal health record shall also
33 incorporate additional data, such as laboratory results, prescription
34 history, claims history, and personal health information authorized
35 or provided by the enrollee. Inclusion of this additional data shall
36 be at the option of the enrollee.

37 (d) Systems or software that pertain to the personal health record
38 shall adhere to accepted national standards for interoperability,
39 privacy, and data exchange, or shall be certified by a nationally
40 recognized certification body.

1 (e) The personal health record shall comply with applicable
2 state and federal confidentiality and data security requirements.

3 SEC. 16. Section 22830.6 is added to the Government Code,
4 to read:

5 22830.6. On or before January 1, 2010, the board shall provide
6 or arrange for the provision of a Healthy Action Incentives and
7 Rewards Program, as described in subdivision (c) of Section
8 1367.38 of the Health and Safety Code, to all enrollees.

9 SEC. 17. Chapter 1.6 (commencing with Section 155) is added
10 to Part 1 of Division 1 of the Health and Safety Code, to read:

11
12 CHAPTER 1.6. CALIFORNIA HEALTH BENEFITS SERVICE
13

14 155. (a) The California Health Benefits Service Program is
15 hereby created within the State Department of Health Care Services
16 for the purposes of expanding cost-effective health coverage
17 options to purchasers governed by the Health Care Security and
18 Cost Reduction Act. The program shall do all of the following:

19 (1) Identify statutory, regulatory, or financial barriers or
20 incentives that should be addressed to facilitate the establishment
21 and maintenance of one or more joint ventures between health
22 plans that contract with, or are governed, owned, or operated by,
23 a county board of supervisors, a county special commission, a
24 county-organized health system or a county health authority
25 authorized by Section 14018.7, 14087.31, 14087.35, 14087.36,
26 14087.38, 14087.96 or Article 2.8 (commencing with Section
27 14087.5) of Chapter 7 of Division 9 of Part 3 of the Welfare and
28 Institutions Code, as well as the County Medical Services Program.

29 (2) Identify statutory, regulatory, or financial barriers or
30 incentives that should be addressed before joint ventures among
31 these health plans may be formed, or existing health plans or the
32 County Medical Services Program may expand to serve other
33 geographic areas, for the purposes of providing public health care
34 services in counties where there is not a local initiative or
35 county-organized health plan that contracts with the State
36 Department of Health Care Services, or the County Medical
37 Services Program, participating in these joint ventures.

38 (3) Report these initial findings to the committees of jurisdiction
39 in the Senate and Assembly on or before January 15, 2009.

1 (4) Provide technical assistance to local health care delivery
2 entities, including local initiatives, county-organized health
3 systems, and the County Medical Services Program, to support
4 joint ventures and efforts by these entities to expand to serve other
5 geographic areas and specified populations, or to contract with
6 providers to provide health care services in counties where there
7 is not a local initiative or county-organized health plan that
8 contracts with the State Department of Health Care Services that
9 opts to participate in such joint ventures, or participation from the
10 County Medical Services Program.

11 (5) Consistent with the report and recommendations provided
12 pursuant to this section and consistent with existing law, the
13 department is authorized to enter into contracts with joint ventures
14 authorized pursuant to this section to provide medical services to
15 specified populations, as determined by the program.

16 (b) Health plans that contract with or are governed, owned, or
17 operated by, a county board of supervisors, a county special
18 commission, a county-organized health system, or county health
19 authority authorized by Section 14018.7, 14087.31, 14087.35,
20 14087.36, 14087.38, or 14087.96 or Article 2.8 (commencing with
21 Section 14087.5) of Chapter 7 of Division 9 of Part 3 of the
22 Welfare and Institutions Code, and the County Medical Services
23 Program, are authorized to form joint ventures to create integrated
24 networks of public health plans that pool risk and share networks.

25 (1) In forming joint ventures, participating health plans shall
26 seek to contract with designated public hospitals, county health
27 clinics, community health centers, and other traditional safety net
28 providers.

29 (2) All joint ventures and health care networks established
30 pursuant to this section shall seek licensure as a health care service
31 plan consistent with the Knox-Keene Health Care Service Plan
32 Act of 1975 (Chapter 2.2 (commencing with Section 1340) of
33 Division 2 of the Health and Safety Code). Prior to commencement
34 of enrollment, the joint venture or health care network shall be
35 licensed pursuant to that act.

36 (c) There is hereby created the California Health Benefits
37 Service Program Stakeholder Committee. The committee shall be
38 comprised of 10 members appointed by the Director of Health
39 Care Services, the Senate Committee on Rules, and the Speaker
40 of the Assembly. The director shall appoint six members including

1 two representatives of local initiatives authorized under the Welfare
2 and Institutions Code, a representative of county-organized health
3 systems, a representative of the County Medical Services Program,
4 a representative of health care providers, and a representative of
5 employers. The Senate Committee on Rules shall appoint two
6 members including a labor representative and a representative of
7 health care consumers. The Speaker of the Assembly shall appoint
8 two members, including a representative of local initiatives
9 authorized under the Welfare and Institutions Code, and a
10 representative of organized labor. The committee shall meet at
11 least quarterly to provide input to the program and assist the
12 program in carrying out its responsibilities as outlined in this
13 section.

14 (d) On or before November 1, 2009, and annually thereafter,
15 the department, with input from the committee, shall update the
16 committees of jurisdiction in the Senate and Assembly on
17 implementation of this section and make recommendations, as
18 applicable, on changes necessary to implement this section. The
19 update shall also include progress on fulfilling the intent of the
20 Health Care Security and Cost Reduction Act and recommendations
21 on resources, policy, and legislative changes necessary to build
22 and implement a system of public health coverage throughout
23 California. The update shall describe the projects proposed or
24 established pursuant to this section, including, but not limited to,
25 the participating providers, the groups covered, the physicians and
26 hospitals in the network, and the counties served.

27 (e) The program shall consult with relevant departments,
28 including the Department of Managed Health Care, in the
29 implementation of this section.

30 (f) Nothing in this section shall be construed to prohibit any
31 other licensed health care service plan not mentioned in
32 subdivisions (b) and (c) from entering in joint ventures or contracts
33 with the State Department of Health Care Services to provide
34 services in counties in which there is not a Medi-Cal managed care
35 health plan that contracts with the department.

36 SEC. 18. Section 1262.9 is added to the Health and Safety
37 Code, to read:

38 1262.9. (a) If a patient has coverage for emergency health care
39 services and poststabilizing care, a noncontracting hospital shall
40 not bill the patient for emergency health care services and

1 poststabilizing care, except for applicable copayments and cost
2 shares.

3 (b) The noncontracting hospital and the health care service plan
4 or health insurer shall each retain their right to pursue all currently
5 available legal remedies they may have against each other,
6 including the right to determine the final payment due.

7 (c) For the purposes of this section:

8 (1) “Noncontracting hospital” means a general acute care
9 hospital as defined in subdivision (a) of Section 1250 that has a
10 special permit to operate an emergency medical service and does
11 not have a contract with a health care service plan or a health
12 insurer for the provision of emergency health care services and
13 poststabilizing care to the patient, who is one of that health care
14 service plan’s or health insurer’s enrollees, members, or insureds.

15 (2) “Emergency health care services and poststabilizing care”
16 means emergency services and out-of-area urgent services provided
17 in an emergency department and a hospital through discharge in
18 compliance with Sections 1262.8 and 1317 and, in the case of
19 health care service plans, the services required to be covered
20 pursuant to paragraph (6) of subdivision (b) of Section 1345,
21 subdivision (i) of Section 1367, Sections 1371.4, and 1371.5, of
22 this code, and Sections 1300.67(g) and 1300.71.4 of Title 28 of
23 the California Code of Regulations.

24 SEC. 19. Section 1342.9 is added to the Health and Safety
25 Code, to read:

26 1342.9. (a) Notwithstanding any other provision of this chapter,
27 a health care service plan that provides services to a beneficiary
28 of the Medi-Cal program pursuant to Article 2.7 (commencing
29 with Section 14087.3), Article 2.8 (commencing with Section
30 14087.5), or Article 2.91 (commencing with Section 14089) of
31 Chapter 7 of, or Article 1 (commencing with Section 14200) or
32 Article 7 (commencing with Section 14490) of Chapter 8 of, Part
33 3 of Division 9 of the Welfare and Institutions Code shall,
34 regarding coverage for participants in a Medi-Cal managed care
35 program, be subject solely to the filing, reporting, monitoring, and
36 survey requirements established by the State Department of Health
37 Care Services for the Medi-Cal managed care program as those
38 requirements pertain to the following subjects: advertising and
39 marketing; member materials, including member handbooks,
40 evidences of coverage, and disclosure forms; and product design,

1 including its scope and limitations. A health care service plan that
2 satisfies any of the foregoing filing, reporting, monitoring, or
3 survey requirements shall be deemed in compliance with
4 corresponding provisions, if any, of this chapter.

5 (b) The department and the State Department of Health Care
6 Services shall develop a joint filing and review process for medical
7 quality surveys required pursuant to Section 1380 and pursuant to
8 Chapter 8 (commencing with Section 14200) of Part 3 of Division
9 9 of the Welfare and Institutions Code.

10 SEC. 20. Section 1347 is added to the Health and Safety Code,
11 to read:

12 1347. The director is authorized to provide regulatory and
13 program flexibilities to facilitate new, modified, or combined
14 licenses of local initiatives and county-organized health systems,
15 created pursuant to Section 155 or the California Health Benefits
16 Service Program (Chapter 1.6 (commencing with Section 155) of
17 Part 1 of Division 1), that seek licensure for regional or statewide
18 networks for the purposes of contracting with the Managed Risk
19 Medical Insurance Board as a participating plan in the California
20 Cooperative Health Insurance Purchasing Program, or for the
21 purposes of providing coverage in the individual and group
22 coverage markets. In providing those flexibilities, the director shall
23 ensure that the health plans established pursuant to this section
24 meet essential financial, capacity, and consumer protection
25 requirements of this chapter.

26 SEC. 20.5. Section 1356.2 is added to the Health and Safety
27 Code, to read:

28 1356.2. (a) It is the intent of the Legislature to establish
29 mechanisms by which the state may defray the costs of an
30 enrollee’s public program participation. The state’s efforts may
31 include, but shall not be limited to, creating mechanisms to take
32 advantage of other opportunities for coverage available to that
33 enrollee, to access nonstate resources available to fund care for
34 that enrollee, or other mechanisms to minimize state costs.

35 (b) (1) The State Department of Health Care Services, in
36 consultation with the Department of Insurance and the Department
37 of Managed Health Care, shall evaluate and consider the options
38 to effectuate the intent of this section and determine the process
39 and procedures to implement subdivision (a). The departments
40 shall assess the fiscal ramifications and administrative feasibility

1 of potential options, and determine the requirements that best
2 effectuate and implement this section. The department shall report
3 its findings to the Joint Legislative Budget Committee by July 1,
4 2009.

5 (2) Ninety days following the department's notification to the
6 Joint Legislative Budget Committee pursuant to paragraph (1), the
7 departments shall implement the policies, procedures, and
8 requirements described in its report.

9 (c) To the extent necessary to achieve the purposes of
10 subdivision (a), the State Department of Health Care Services may
11 implement Section 1396e of Title 42 of the United States Code.
12 To the extent necessary to achieve the purposes of this section,
13 this option shall be exercised in conjunction with the benchmark
14 authority provided in Section 1396u-7 of Title 42 of the United
15 States Code.

16 (d) To the extent necessary to achieve the purposes of
17 subdivision (a), the Department of Insurance and the Department
18 of Managed Health Care shall establish appropriate licensing
19 requirements for health insurers and health care service plans to
20 permit the state to access funds and contributions available to
21 enrollees to reduce the cost of subsidized coverage.

22 (e) For the purposes of implementing this section, the State
23 Department of Health Care Services, the Department of Insurance,
24 and the Department of Managed Health Care shall promulgate
25 regulations in accordance with the requirements of Chapter 3.5
26 (commencing with Section 11340) of Part 1 of Division 3 of Title
27 2 of the Government Code.

28 (f) For the purposes of this section, "subsidized coverage" means
29 coverage provided under either of the following:

30 (1) Part 6.45 (commencing with Section 12699.201) of Division
31 2 of the Insurance Code through a Cal-CHIPP Healthy Families
32 plan.

33 (2) Section 14005.333 of the Welfare and Institutions Code.

34 (g) This section shall be implemented no later than one year
35 from the date that the act enacting this section becomes operative.

36 SEC. 21. Section 1357.54 of the Health and Safety Code is
37 amended to read:

38 1357.54. All individual health benefit plans, except for
39 short-term limited duration insurance, shall be renewable with

1 respect to all eligible individuals or dependents at the option of
2 the individual except as follows:

3 (a) For nonpayment of the required premiums or contributions
4 by the individual in accordance with the terms of the health
5 insurance coverage or the timeliness of the payments.

6 (b) For fraud or intentional misrepresentation of material fact
7 under the terms of the coverage by the individual.

8 (c) Movement of the individual contractholder outside the
9 service area, but only if the coverage is terminated uniformly
10 without regard to any health status-related factor of covered
11 individuals.

12 (d) If the plan ceases to provide or arrange for the provision of
13 health care services for new individual health benefit plans in this
14 state; provided, however, that the following conditions are satisfied:

15 (1) Notice of the decision to cease new or existing individual
16 health benefit plans in the state is provided to the director and to
17 the individual at least 180 days prior to discontinuation of that
18 coverage.

19 (2) Individual health benefit plans shall not be canceled for 180
20 days after the date of the notice required under paragraph (1) and
21 for that business of a plan that remains in force, any plan that ceases
22 to offer for sale new individual health benefit plans shall continue
23 to be governed by this section with respect to business conducted
24 under this section.

25 (3) A plan that ceases to write new individual health benefit
26 plans in this state after the effective date of this section shall be
27 prohibited from offering for sale individual health benefit plans
28 in this state for a period of five years from the date of notice to the
29 director.

30 (e) If the plan withdraws an individual health benefit plan from
31 the market; provided, that the plan notifies all affected individuals
32 and the director at least 90 days prior to the discontinuation of
33 these plans, and that the plan makes available to the individual all
34 health benefit plans that it makes available to new individual
35 business without regard to any health status-related factor of
36 enrolled individuals or individuals who may become eligible for
37 the coverage.

38 This section shall become inoperative on the date that Section
39 1399.829 becomes operative.

1 SEC. 22. Section 1365 of the Health and Safety Code is
2 amended to read:

3 1365. (a) An enrollment or a subscription may not be canceled
4 or not renewed except for the following:

5 (1) Failure to pay the charge for such coverage if the subscriber
6 has been duly notified and billed for the charge and at least 15
7 days has elapsed since the date of notification.

8 (2) Fraud or deception in the use of the services or facilities of
9 the plan or knowingly permitting such fraud or deception by
10 another.

11 (3) Such other good cause as is agreed upon in the contract
12 between the plan and a group or the subscriber.

13 (b) An enrollee or subscriber who alleges that an enrollment or
14 subscription has been canceled or not renewed because of the
15 enrollee's or subscriber's health status or requirements for health
16 care services may request a review by the director. If the director
17 determines that a proper complaint exists under the provisions of
18 this section, the director shall notify the plan. Within 15 days after
19 receipt of such notice, the plan shall either request a hearing or
20 reinstate the enrollee or subscriber. If, after hearing, the director
21 determines that the cancellation or failure to renew is contrary to
22 subdivision (a), the director shall order the plan to reinstate the
23 enrollee or subscriber. A reinstatement pursuant to this subdivision
24 shall be retroactive to the time of cancellation or failure to renew
25 and the plan shall be liable for the expenses incurred by the
26 subscriber or enrollee for covered health care services from the
27 date of cancellation or nonrenewal to and including the date of
28 reinstatement.

29 (c) This section shall not abrogate any preexisting contracts
30 entered into prior to the effective date of this chapter between a
31 subscriber or enrollee and a health care service plan or a specialized
32 health care service plan including, but not limited to, the financial
33 liability of that plan, except that each plan shall, if directed to do
34 so by the director, exercise its authority, if any, under any such
35 preexisting contracts to conform them to the provisions of
36 subdivision (a).

37 (d) On and after the date that Section 1399.829 becomes
38 operative, this section shall not apply to individual health plan
39 contracts.

1 SEC. 22.7. Section 1367.16 is added to the Health and Safety
2 Code, to read:

3 1367.16. For purposes of subdivision (c) of Section 1367.15,
4 “comparable benefits” means any health plan contract in the same
5 coverage choice category, as determined by the department and
6 the Department of Insurance pursuant to Section 1399.832, that a
7 closed block of business would have been in, had that block of
8 business not been closed. If the coverage benefits provided in the
9 closed block of business do not meet or exceed the minimum health
10 care coverage requirements of Section 1399.824, they shall be
11 deemed comparable to the lowest coverage choice category.

12 SEC. 23. Section 1367.205 is added to the Health and Safety
13 Code, to read:

14 1367.205. Commencing on or before January 1, 2010, a health
15 care service plan that provides prescription drug benefits and
16 maintains one or more drug formularies shall make the most current
17 formularies available electronically to prescribers and pharmacies.

18 SEC. 24. Section 1367.38 is added to the Health and Safety
19 Code, to read:

20 1367.38. (a) On and after January 1, 2009, every health care
21 service plan, except for a Medicare supplement plan, that covers
22 hospital, medical, or surgical expenses on a group basis shall offer
23 to include a Healthy Action Incentives and Rewards Program, as
24 described in subdivision (b), to be implemented in connection with
25 a health care service plan, under such terms and conditions as may
26 be agreed upon between the subscriber group and the health care
27 service plan. Every plan shall communicate the availability of that
28 program to all prospective subscriber groups with whom it is
29 negotiating and to existing subscriber groups upon renewal.

30 (b) For purposes of this section, benefits under a Healthy Action
31 Incentives and Rewards Program shall provide for all of the
32 following, where appropriate:

33 (1) Health risk appraisals to be used to assess an individual’s
34 overall health status and to identify risk factors, including, but not
35 limited to, smoking and smokeless tobacco use, alcohol abuse,
36 drug use, and nutrition and physical activity practices.

37 (2) Enrollee access to an appropriate health care provider, as
38 medically necessary, to review and address the results of the health
39 risk appraisal. In addition, where appropriate, the Healthy Action
40 Incentives and Rewards Program may include followup through

1 a Web-based tool or a nurse hotline either in combination with a
2 referral to a provider or separately.

3 (3) Incentives or rewards for enrollees to become more engaged
4 in their health care and to make appropriate choices that support
5 good health, including obtaining health risk appraisals, screening
6 services, immunizations, or participating in healthy lifestyle
7 programs and practices. These programs and practices may include,
8 but need not be limited to, smoking cessation, physical activity,
9 or nutrition. Incentives may include, but need not be limited to,
10 health premium reductions, differential copayment or coinsurance
11 amounts, and cash payments. Rewards may include, but need not
12 be limited to, nonprescription pharmacy products or services not
13 otherwise covered under an enrollee's health plan contract, exercise
14 classes, gym memberships, and weight management programs. If
15 a health care service plan elects to offer an incentive in the form
16 of a reduction in the premium amount, the premium reduction shall
17 be standardized and uniform for all groups and subscribers and
18 shall be offered only after the successful completion of the
19 specified program or practice by the enrollee or subscriber.

20 (c) (1) A health care service plan subject to this section shall
21 offer and price all Healthy Action Incentives and Rewards
22 Programs approved by the director consistently across all groups,
23 potential groups, and individuals and offer and price the programs
24 without regard to the health status, prior claims experience, or risk
25 profile of the members of a group. A health plan shall not condition
26 the offer, delivery, or renewal of a contract that covers hospital,
27 medical, or surgical expenses on the group's purchase, acceptance,
28 or enrollment in a Healthy Action Incentives and Rewards Program.
29 Rewards and incentives established in the program may not be
30 designed, provided, or withheld based on the actual health service
31 utilization or health care claims experience of the group, members
32 of the group, or the individual.

33 (2) In order to demonstrate compliance with this section, a health
34 care service plan shall file the program description and design as
35 an amendment to its application for licensure pursuant to
36 subdivision (a) of Section 1352. The director shall disapprove,
37 suspend, or withdraw any product or program developed pursuant
38 to this section if the director determines that the product or product
39 design has the effect of allowing health care service plans to
40 market, sell, or price health coverage for healthier lower risk profile

1 groups in a preferential manner that is inconsistent with the
2 requirement to offer, market, and sell products pursuant to Article
3 3.1 (commencing with Section 1357) and Article 11.6
4 (commencing with Section 1399.820).

5 (d) This section shall supplement, and not supplant, any other
6 section in this chapter concerning requirements for plans to provide
7 health care services, childhood immunizations, adult
8 immunizations, and preventive care services.

9 (e) This section shall only be implemented if and to the extent
10 allowed under federal law. If any portion of this section is held to
11 be invalid, as determined by a final judgment of a court of
12 competent jurisdiction, this section shall become inoperative.

13 SEC. 25. Section 1368.025 is added to the Health and Safety
14 Code, to read:

15 1368.025. In addition to the duties listed in paragraph (3) of
16 subdivision (c) of Section 1368.02, the duties of the Office of
17 Patient Advocate shall include providing access to the public to
18 reports and data obtained by the Office of Statewide Health
19 Planning and Development in a format and through mechanisms,
20 including, but not limited to, the Internet, that allow the public to
21 use the information to assist them in making informed selections
22 of health plans, hospitals, medical groups, nursing homes, and
23 other providers about whom the office has collected information.

24 SEC. 26. Section 1378.1 is added to the Health and Safety
25 Code, to read:

26 1378.1. (a) Except as provided in subdivision (f), a full-service
27 health care service plan shall, on and after July 1, 2010, expend
28 in the form of health care benefits no less than 85 percent of the
29 aggregate dues, fees, premiums, or other periodic payments
30 received by the plan. For purposes of this section, the plan may
31 deduct from the aggregate dues, fees, premiums, or other periodic
32 payments received by the plan the amount of income taxes or other
33 taxes that the plan expensed. For purposes of this section, “health
34 care benefits” shall mean health care services that are either
35 provided by or reimbursed by the plan or its contracted providers
36 as plan benefits.

37 (b) (1) In addition to the health care benefits defined in
38 subdivision (a), health care benefits shall include:

39 (A) The costs of programs or activities, including training and
40 the provision of informational materials that are determined as

1 part of the regulations under subdivision (d) to improve the
2 provision of quality care, improve health care outcomes, or
3 encourage the use of evidence-based medicine.

4 (B) Disease management expenses using cost-effective
5 evidence-based guidelines.

6 (C) Plan medical advice by telephone.

7 (D) Payments to providers as risk pool payments of
8 pay-for-performance initiatives.

9 (2) Health care benefits shall not include administrative costs
10 listed in Section 1300.78 of Title 28 of the California Code of
11 Regulations in effect on January 1, 2007.

12 (c) To assess compliance with this section, a plan licensed to
13 operate in California may average its total costs across all health
14 care service plan contracts issued, amended, or renewed in
15 California, and all health insurance policies issued, amended, or
16 renewed by its affiliated disability insurers with valid California
17 certificates of authority, except for those policies listed in
18 subdivision (f) of Section 10113.10 of the Insurance Code.

19 (d) The department and the Department of Insurance shall jointly
20 adopt and amend regulations to implement this section and Section
21 10113.10 of the Insurance Code to establish uniform reporting by
22 plans and insurers of the information necessary to determine
23 compliance with this section. These regulations may include
24 additional elements in the definition of health care benefits not
25 identified in paragraph (1) of subdivision (b) in order to
26 consistently operationalize the requirements of this section among
27 health plans and health insurers, but such regulatory additions shall
28 be consistent with the legislative intent that health plans expend
29 at least 85 percent of aggregate payments as provided in
30 subdivision (a) on health care benefits.

31 (e) The department may exclude from the determination of
32 compliance with the requirement of subdivision (a) any new health
33 care service plan contracts for up to the first two years that these
34 contracts are offered for sale in California, provided that the
35 director determines that the new contracts are substantially different
36 from the existing contracts being issued, amended, or renewed by
37 the health plan seeking the exclusion.

38 (f) This section shall not apply to Medicare supplement plans
39 or to coverage offered by specialized health care service plans,

1 including, but not limited to, ambulance, dental, vision, behavioral
2 health, chiropractic, and naturopathic.

3 SEC. 27. Section 1395.2 is added to the Health and Safety
4 Code, to read:

5 1395.2. (a) A health care service plan may provide notice by
6 electronic transmission and shall be deemed to have fully complied
7 with the specific statutory or regulatory requirements to provide
8 notice by United States mail to an applicant, enrollee, or subscriber,
9 if it complies with all of the following requirements:

10 (1) Obtains authorization from the applicant, enrollee, or
11 subscriber to provide notices by electronic transmission and to
12 cease providing notices by United States mail. "Authorization"
13 means the agreement by the applicant, enrollee, or subscriber
14 through interactive voice response, the Internet or other similar
15 medium, or in writing, to receive notices by electronic transmission.

16 (2) Uses an authorization process, approved by the department,
17 in which the applicant, enrollee, or subscriber confirms
18 understanding of and agreement with the specific notices or
19 materials that will be provided by electronic transmission.

20 (3) Complies with the specific statutory or regulatory
21 requirements as to the content of the notices it sends by electronic
22 transmission.

23 (4) Provides for the privacy of the notice as required by state
24 and federal laws and regulations.

25 (5) Allows the applicant, enrollee, or subscriber at any time to
26 terminate the authorization to provide notices by electronic
27 transmission and receive the notices through the United States
28 mail, if specific statutory or regulatory requirements require notice
29 by mail.

30 (6) Sends the electronic transmission of a notice to the last
31 known electronic address of the applicant, enrollee, or subscriber.
32 If the electronic transmission fails to reach its intended recipient
33 twice, the health care service plan shall resume sending all notices
34 to the last known United States mail address of the applicant,
35 enrollee, or subscriber.

36 (7) Maintains an Internet Web site where the applicant, enrollee,
37 or subscriber may access the notices sent by electronic
38 transmission.

1 (8) Informs the applicant, enrollee, or subscriber how to
2 terminate the authorization to provide notices sent by electronic
3 transmission.

4 (b) A health care service plan shall not use the electronic mail
5 address of an applicant, enrollee, or subscriber that it obtained for
6 the purposes of providing notice pursuant to subdivision (a) for
7 any purpose other than communicating with the enrollee, applicant,
8 or subscriber about his or her policy, plan, or benefits.

9 (c) No person other than the applicant, enrollee, or subscriber
10 to whom the medical information in the notice pertains or a
11 representative lawfully authorized to act on behalf of the applicant,
12 enrollee, or subscriber, may authorize the transmission of medical
13 information by electronic transmission. “Medical information” for
14 these purposes shall have the meaning set forth in subdivision (g)
15 of Section 56.05 of the Civil Code. The transmission of any
16 medical information, as that term is used in subdivision (g) of
17 Section 56.05 of the Civil Code, shall comply with the
18 Confidentiality of Medical Information Act (Part 2.6 (commencing
19 with Section 56) of Division 1 of the Civil Code).

20 (d) A notice transmitted electronically pursuant to this section
21 is a private and confidential communication, and it shall constitute
22 a violation of this chapter for a person, other than the applicant,
23 enrollee, or subscriber to whom the notice is addressed, to read or
24 otherwise gain access to the notice without the express, specific
25 permission of the notice’s addressee. This subdivision shall not
26 apply to a health care provider, health care service plan, or
27 contractor of a health care provider or health care service plan, of
28 an applicant, enrollee, or subscriber if the health care provider,
29 health care service plan, or contractor of a health care provider or
30 health care service plan is authorized to have access to the medical
31 information pursuant to the Confidentiality of Medical Information
32 Act (Part 2.6 (commencing with Section 56) of Division 1 of the
33 Civil Code).

34 (e) A health care service plan shall not impose additional fees
35 or a differential if an applicant, enrollee, or subscriber elects not
36 to receive notices by electronic transmission.

37 (f) Notices that may be made by electronic transmission include
38 an explanation of benefits; responses to inquiries from an applicant,
39 enrollee, or subscriber; underwriting decisions; distribution of plan
40 contracts, including evidence of coverage and disclosure forms

1 pursuant to Sections 1300.63.1 and 1300.63.2 of Title 28 of the
 2 California Code of Regulations; a list of contracting providers
 3 pursuant to Section 1367.26; and changes in rates or coverage
 4 pursuant to Sections 1374.21, 1374.22, and 1374.23. A plan may
 5 not transmit through electronic means any notice that may affect
 6 the eligibility for, or continued enrollment in, coverage.

7 SEC. 27.3. Section 1399.56 of the Health and Safety Code is
 8 amended to read:

9 1399.56. (a) Compensation of a person retained by a health
 10 care service plan to review claims for health care services shall
 11 not be based on either of the following:

- 12 (1) A percentage of the amount by which a claim is reduced for
 13 payment.
- 14 (2) The number of claims or the cost of services for which the
 15 person has denied authorization or payment.

16 (b) This section shall become inoperative on December 1, 2008,
 17 and, as of January 1, 2009, is repealed, unless a later enacted
 18 statute, that becomes operative on or before January 1, 2009,
 19 deletes or extends the dates on which it becomes inoperative and
 20 is repealed.

21 SEC. 27.5. Section 1399.56 is added to the Health and Safety
 22 Code, to read:

23 1399.56. (a) Compensation of a person employed by or
 24 contracted with a health care service plan to review claims or
 25 eligibility for health care services shall not be based on either of
 26 the following:

- 27 (1) A percentage of the amount by which a claim is reduced for
 28 payment.
- 29 (2) The number of claims or the cost of services for which the
 30 person has denied authorization or payment.

31 (b) This section shall become operative on December 1, 2008.

32 SEC. 28. Section 1399.58 is added to the Health and Safety
 33 Code, to read:

34 1399.58. (a) No health care service plan shall set performance
 35 goals or quotas or provide additional compensation to any person
 36 employed by or contracted with the health care service plan based
 37 on the number of persons for which coverage is rescinded or the
 38 financial savings to the health care service plan associated with
 39 the rescission of coverage.

40 (b) This section shall become operative on December 1, 2008.

1 SEC. 28.5. Article 11.6 (commencing with Section 1399.820)
2 is added to Chapter 2.2 of Division 2 of the Health and Safety
3 Code, to read:

4

5 Article 11.6. Individual Market Reform and Guarantee Issue

6

7 1399.820. It is the intent of the Legislature to do both of the
8 following:

9 (a) Guarantee the availability and renewability of health
10 coverage to individuals through the private health insurance market.

11 (b) Require that health care service plans and health insurers
12 issuing coverage in the individual market compete on the basis of
13 price, quality, and service, and not on risk selection.

14 1399.821. For purposes of this article, the following terms shall
15 have the following meanings:

16 (a) “Anniversary date” means the calendar date one year from,
17 and each subsequent year thereafter, the date an individual enrolls
18 in a health plan contract.

19 (b) “Coverage choice category” means the category of health
20 plan contracts and health insurance policies established by the
21 department and the Department of Insurance pursuant to Section
22 1399.832.

23 (c) “Dependent” means the spouse, registered domestic partner,
24 or child of an individual, subject to applicable terms of the health
25 plan contract covering the individual.

26 (d) “Health insurance policy” means an individual disability
27 insurance policy offered, sold, amended, or renewed to individuals
28 and their dependents and that provides coverage for hospital,
29 medical, or surgical benefits. The term shall not include any of the
30 following kinds of insurance:

31 (1) Accidental death and accidental death and dismemberment.

32 (2) Disability insurance, including hospital indemnity,
33 accident-only, and specified disease insurance that pays benefits
34 on a fixed benefit, cash-payment-only basis.

35 (3) Credit disability, as defined in Section 779.2 of the Insurance
36 Code.

37 (4) Coverage issued as a supplement to liability insurance.

38 (5) Disability income, as defined in subdivision (i) of Section
39 799.01 of the Insurance Code.

1 (6) Insurance under which benefits are payable with or without
2 regard to fault and that is statutorily required to be contained in
3 any liability insurance policy or equivalent self-insurance.

4 (7) Insurance arising out of a workers’ compensation or similar
5 law.

6 (8) Long-term care coverage.

7 (9) Dental coverage.

8 (10) Vision coverage.

9 (11) Medicare supplement, CHAMPUS-supplement or
10 Tricare-supplement, behavioral health-only, pharmacy-only,
11 hospital indemnity, hospital-only, accident-only, or specified
12 disease insurance that does not pay benefits on a fixed benefit,
13 cash-payment-only basis.

14 (e) “Health insurer” means a disability insurer that offers and
15 sells health insurance.

16 (f) “Health plan” means a health care service plan, as defined
17 in subdivision (f) of Section 1345, that is lawfully engaged in
18 providing, arranging, paying for, or reimbursing the cost of health
19 care services and is offering or selling health care service plan
20 contracts in the individual market. A health plan shall not include
21 a specialized health care service plan.

22 (g) “Health plan contract” means an individual health care
23 service plan contract offered, sold, amended, or renewed to
24 individuals and their dependents. The term shall not include
25 long-term care insurance, dental, or vision coverage. In addition,
26 the term shall not include a specialized health care service plan
27 contract, as defined in subdivision (o) of Section 1345.

28 (h) “Purchasing pool” means the program established under
29 Part 6.45 (commencing with Section 12699.201) of Division 2 of
30 the Insurance Code.

31 (i) “Rating period” means the period for which premium rates
32 established by a plan are in effect and shall be no less than 12
33 months beginning on the effective date of the subscriber’s health
34 plan contract.

35 (j) “Risk adjustment factor” means the percentage adjustment
36 to be applied to the standard risk rate for a particular individual,
37 based upon any expected deviations from standard claims due to
38 the health status of the individual.

1 (k) “Risk category” means the following characteristics of an
2 individual: age, geographic region, and family composition of the
3 individual, plus the health plan contract selected by the individual.

4 (1) No more than the following age categories may be used in
5 determining premium rates:

6 Under 1.

7 1–18.

8 19–24.

9 25–29.

10 30–34.

11 35–39.

12 40–44.

13 45–49.

14 50–54.

15 55–59.

16 60–64.

17 65 and over.

18 However, for the 65 and over age category, separate premium
19 rates may be specified depending upon whether coverage under
20 the health plan contract will be primary or secondary to benefits
21 provided by the federal Medicare Program pursuant to Title XVIII
22 of the federal Social Security Act.

23 (2) Health plans shall determine rates using no more than the
24 following family size categories:

25 (A) Single.

26 (B) More than one child 18 years of age or under and no adults.

27 (C) Married couple or registered domestic partners.

28 (D) One adult and child.

29 (E) One adult and children.

30 (F) Married couple and child or children, or registered domestic
31 partners and child or children.

32 (3) (A) In determining rates for individuals, a health plan that
33 operates statewide shall use no more than nine geographic regions
34 in the state, have no region smaller than an area in which the first
35 three digits of all its ZIP Codes are in common within a county,
36 and divide no county into more than two regions. Health plans
37 shall be deemed to be operating statewide if their coverage area
38 includes 90 percent or more of the state’s population. Geographic
39 regions established pursuant to this section shall, as a group, cover
40 the entire state, and the area encompassed in a geographic region

1 shall be separate and distinct from areas encompassed in other
2 geographic regions. Geographic regions may be noncontiguous.

3 (B) (i) In determining rates for individuals, a plan that does not
4 operate statewide shall use no more than the number of geographic
5 regions in the state that is determined by the following formula:
6 the population, as determined in the last federal census, of all
7 counties that are included in their entirety in a plan's service area
8 divided by the total population of the state, as determined in the
9 last federal census, multiplied by nine. The resulting number shall
10 be rounded to the nearest whole integer. No region may be smaller
11 than an area in which the first three digits of all its ZIP Codes are
12 in common within a county and no county may be divided into
13 more than two regions. The area encompassed in a geographic
14 region shall be separate and distinct from areas encompassed in
15 other geographic regions. Geographic regions may be
16 noncontiguous. No health plan shall have less than one geographic
17 area.

18 (ii) If the formula in clause (i) results in a health plan that
19 operates in more than one county having only one geographic
20 region, then the formula in clause (i) shall not apply and the health
21 plan may have two geographic regions, provided that no county
22 is divided into more than one region.

23 Nothing in this section shall be construed to require a health plan
24 to establish a new service area or to offer health coverage on a
25 statewide basis, outside of the health plan's existing service area.

26 (4) A health plan may rate its entire portfolio of health plan
27 contracts in accordance with expected costs or other market
28 considerations, but the rate for each health plan contract shall be
29 set in relation to the balance of the portfolio, as certified by an
30 actuary.

31 (5) Each health plan contract shall be priced as determined by
32 each health plan to reflect the difference in benefit variation, or
33 the effectiveness of a provider network, and each health plan may
34 adjust the rate for a specific plan contract for risk selection only
35 to the extent permitted by subdivision (d) of Section 1399.840.

36 (l) "Standard risk rate" means the rate applicable to an individual
37 in a particular risk category.

38 (m) "Subscriber" means the individual who is enrolled in a
39 health plan contract, is the basis for eligibility for enrollment in
40 the contract, and is responsible for payment to the health plan.

1 1399.823. On and after March 31, 2009, a health plan shall not
2 offer to an individual a health plan contract that provides less than
3 minimum creditable coverage as defined by the Managed Risk
4 Medical Insurance Board pursuant to Section 12739.50 of the
5 Insurance Code.

6 1399.826. (a) Notwithstanding Chapter 15 (commencing with
7 Section 8899.50) of Division 1 of Title 2 of the Government Code
8 and Section 1399.823, a health plan may renew an individual health
9 care benefit plan for anyone enrolled on March 1, 2009, indefinitely
10 without increasing benefits to meet the required minimum
11 creditable coverage established by the Managed Risk Medical
12 Insurance Board pursuant to Section 12739.50 of the Insurance
13 Code. Those individual health care benefit plans, however, may
14 not be offered to new enrollment, unless they are amended to meet
15 the minimum creditable coverage established by the Managed Risk
16 Medical Insurance Board pursuant to Section 12739.50 of the
17 Insurance Code. In offering those plans for renewal, rates
18 determined by health plans shall meet the requirements of Sections
19 1399.821 and 1399.840. An individual who maintains coverage
20 in a health plan contract pursuant to this section shall be deemed
21 to be in compliance with Section 8899.50 of the Government Code.

22 (b) A health plan shall not cease to renew coverage in an
23 individual health plan contract described in subdivision (a) except
24 as permitted pursuant to Section 1367.15.

25 (c) On and after March 1, 2009, the director shall not approve
26 for offer and sale in this state any new individual health plan
27 contract that does not meet or exceed the requirements for
28 minimum creditable coverage established by the Managed Risk
29 Medical Insurance Board pursuant to Section 12739.50 of the
30 Insurance Code.

31 (d) Effective July 1, 2010, all individual health plan contracts
32 approved, offered, and sold prior to March 1, 2009, which do not
33 comply with minimum creditable coverage standards adopted by
34 the Managed Risk Medical Insurance Board pursuant to Section
35 12739.50 of the Insurance Code, exclusively because the contract
36 includes a lifetime benefit maximum inconsistent with minimum
37 creditable coverage requirements, shall be modified to comply
38 with the minimum creditable coverage standard.

39 (e) This section shall become operative on January 1, 2009.

1 1399.827. A health plan shall, in addition to complying with
2 this chapter and the rules of the director, comply with this article.

3 1399.828. This article shall not apply to health plan contracts
4 for coverage of Medicare services pursuant to contracts with the
5 United States government, Medicare supplement, Medi-Cal
6 contracts with the State Department of Health Care Services,
7 Healthy Families Program contracts with the Managed Risk
8 Medical Insurance Board, long-term care coverage, specialized
9 health care service plan contracts, as defined in subdivision (o) of
10 Section 1345, or the purchasing pool established under Part 6.45
11 (commencing with Section 12699.201) of Division 2 of the
12 Insurance Code.

13 1399.829. (a) Except for the health plan contracts described
14 in subdivision (a) of Section 1399.826, a health plan shall fairly
15 and affirmatively offer, market, and sell all of the plan's contracts
16 that are sold to individuals to all individuals in each service area
17 in which the health plan provides or arranges for the provision of
18 health care services.

19 (b) A health plan may not reject an application from an
20 individual, or his or her dependents, for a health plan contract, or
21 refuse to renew an individual health plan contract, if all of the
22 following requirements are met:

23 (1) The individual agrees to make the required premium
24 payments.

25 (2) The individual and his or her dependents who are to be
26 covered by the health plan contract work or reside in the service
27 area in which the health plan provides or otherwise arranges for
28 the provision of health care services.

29 (3) The individual provides the information requested on the
30 application to determine the appropriate rate.

31 (c) Notwithstanding subdivision (b), if an individual, or his or
32 her dependents, applies for a health plan contract in a coverage
33 choice category for which he or she is not eligible pursuant to
34 Section 1399.837, the health plan may reject that application
35 provided that the plan also offers the individual and his or her
36 dependents coverage in the appropriate coverage choice category.

37 (d) Notwithstanding subdivision (b), a health plan is not required
38 to renew an individual health plan contract if any of the conditions
39 listed in subdivision (a) of Section 1399.839 are met.

1 (e) Notwithstanding any other provision of this chapter or of a
2 health plan contract, every health plan shall comply with the
3 requirements of Chapter 7 (commencing with Section 3750) of
4 Part 1 of Division 9 of the Family Code and Section 14124.94 of
5 the Welfare and Institutions Code.

6 (f) A health plan may require an individual to provide
7 information on his or her health status or health history, or that of
8 his or her dependents, in the application for enrollment to the extent
9 required to apply the risk adjustment factor permitted pursuant to
10 subdivision (d) of Section 1399.840. The health plan shall use the
11 standardized form and process developed by the department
12 pursuant to Section 1399.840. After the health plan contract's
13 effective date of coverage, a health plan may request that the
14 subscriber provide information voluntarily on his or her health
15 history or health status, or that of his or her dependents, for
16 purposes of providing care management services, including disease
17 management services.

18 (g) Notwithstanding subdivision (b), a health plan may reject
19 an application for any person who has been a resident of California
20 for six months or less unless one of the following applies: (1) the
21 person is a federally eligible defined individual as defined in
22 Section 1399.801 or Section 10785 of the Insurance Code; or (2)
23 the individual can demonstrate a minimum of two years of prior
24 creditable coverage at least equivalent to the minimum creditable
25 coverage developed by the Managed Risk Medical Insurance Board
26 pursuant to Section 12739.50 of the Insurance Code and provided
27 the person applies for coverage in California within 62 days of
28 termination or cancellation of the prior creditable coverage.

29 (h) Notwithstanding subdivision (b), a health plan may reject
30 an application for coverage from either of the following:

31 (1) A person who is exempt from the requirements of Section
32 8899.50 of the Government Code because the person or family
33 has an income at or below 250 percent of the federal poverty level
34 and the person's or family's share of premium for minimum
35 creditable coverage exceeds 5 percent of his or her family income,
36 except for those individuals meeting the criteria in paragraph (1)
37 or (2) of subdivision (g).

38 (2) A person exempted from the requirements of Section 8899.50
39 of the Government Code pursuant to any exemption authorized or
40 granted by the Managed Risk Medical Insurance Board pursuant

1 to Section 12739.501 of the Insurance Code, for the time period
2 of the exemption, as determined by the board.

3 (i) Notwithstanding Section 1399.846, this section shall not
4 become operative until Section 12739.51 of the Insurance Code
5 is implemented.

6 1399.831. (a) A health plan shall not impose any preexisting
7 condition exclusions, waived conditions, or postenrollment
8 waiting or affiliation periods on any health plan contract issued,
9 amended, or renewed pursuant to this article, except as provided
10 under subdivision (b) of this section.

11 (b) After the requirement to guarantee issue of coverage under
12 Section 1399.826 has been in effect for nine months, a health plan
13 may impose a preexisting condition exclusion of up to 12 months
14 for any person who fails to comply for more than 62 days with the
15 requirement to maintain coverage under Section 8899.50 of the
16 Government Code, providing, however, that the exclusion may
17 not exceed the length of time that the person failed to comply with
18 the requirements of that section. “Preexisting condition exclusion”
19 means a contract provision that excludes coverage for charges or
20 expenses incurred during a specified period following the
21 individual’s effective date of coverage, as to a condition for which
22 medical advice, diagnosis, care, or treatment was recommended
23 or received during a specified period immediately preceding the
24 effective date of coverage. For purposes of this section, preexisting
25 condition provisions contained in plan contracts may relate only
26 to conditions for which medical advice, diagnosis, care, or
27 treatment, including use of prescription drugs, was recommended
28 or received from a licensed health practitioner during the 12 months
29 immediately preceding the effective date of coverage.

30 1399.832. (a) On or before April 1, 2009, the department and
31 the Department of Insurance shall jointly, by regulation, develop
32 a system to categorize all health plan contracts and health insurance
33 policies offered and sold to individuals pursuant to this article and
34 Chapter 9.6 (commencing with Section 10920) of Part 2 of Division
35 2 of the Insurance Code into five coverage choice categories. These
36 coverage choice categories shall do all of the following:

37 (1) Reflect a reasonable continuum between the coverage choice
38 category with the lowest level of health care benefits and the
39 coverage choice category with the highest level of health care
40 benefits.

1 (2) Permit reasonable benefit variation that will allow for a
2 diverse market within each coverage choice category.

3 (3) Be enforced consistently between health plans and health
4 insurers in the same marketplace regardless of licensure.

5 (4) Within each coverage choice category, include one standard
6 health maintenance organization (HMO) and one standard preferred
7 provider organization (PPO), each of which is the health plan
8 contract with the lowest benefit level in that category and for that
9 type of contract.

10 (b) All health plans shall submit filings required pursuant to
11 Section 1399.842 no later than October 1, 2009, for all individual
12 health plan contracts to be offered or sold on or after July 1, 2010,
13 to comply with this article, and thereafter any additional health
14 plan contracts shall be filed pursuant to Section 1399.842. The
15 director shall categorize each health plan contract offered by a
16 health plan into the appropriate coverage choice category on or
17 before March 31, 2010.

18 (c) To facilitate consumer comparison shopping, all health plans
19 that offer coverage on an individual basis shall offer at least one
20 health plan contract in each coverage choice category, including
21 offering at least one of the standard contracts developed pursuant
22 to paragraph (4) of subdivision (a), but a health plan may offer
23 multiple products in each category.

24 (d) If a health plan offers a specific type of health plan contract
25 in one coverage choice category, it must offer that specific type
26 of health plan contract in each coverage choice category. A “type
27 of health plan contract” includes a preferred provider organization,
28 an exclusive provider organization model plan, a point of service
29 model plan, and a health maintenance organization model plan.

30 (e) Health plans shall have flexibility in establishing provider
31 networks, provided that access to care standards pursuant to this
32 chapter are met, and provided that the provider network offered
33 for one health plan contract in one coverage choice category is
34 offered for at least one health plan contract in each coverage choice
35 category.

36 (f) A health plan shall establish prices for its products that reflect
37 a reasonable continuum between the products offered in the
38 coverage choice category with the lowest level of benefits and the
39 products offered in the coverage choice category with the highest
40 level of benefits. A health plan shall not establish a standard risk

1 rate for a product in a coverage choice category at a lower rate
2 than a product offered in a lower coverage choice category.

3 (g) The coverage choice category with the lowest level of
4 benefits shall include the benefits which meet the requirement of
5 minimum creditable coverage as determined by the Managed Risk
6 Medical Insurance Board pursuant to Section 12739.50 of the
7 Insurance Code.

8 1399.833. A health plan shall offer coverage for a Healthy
9 Action Incentives and Rewards Program that complies with the
10 requirements of Section 1367.38 in at least one health plan contract
11 in every coverage choice category.

12 1399.834. The Office of the Patient Advocate shall develop
13 and maintain on its Internet Web site a uniform benefits matrix of
14 all available individual health plan contracts and individual health
15 insurance policies arranged by coverage choice category. This
16 uniform benefit matrix shall include all of the following:

17 (a) Benefit information submitted by health plans pursuant to
18 Section 1399.843 and by health insurers pursuant to Section 10940
19 of the Insurance Code, including, but not limited to, the following
20 category descriptions:

- 21 (1) Deductibles.
- 22 (2) Copayments or coinsurance, as applicable.
- 23 (3) Annual out-of-pocket maximums.
- 24 (4) Professional services.
- 25 (5) Outpatient services.
- 26 (6) Preventive services.
- 27 (7) Hospitalization services.
- 28 (8) Emergency health services.
- 29 (9) Ambulance services.
- 30 (10) Prescription drug coverage.
- 31 (11) Durable medical equipment.
- 32 (12) Mental health and substance abuse services.
- 33 (13) Home health services.
- 34 (14) Other.

35 (b) The telephone number or numbers that may be used by an
36 applicant to contact either the department or the Department of
37 Insurance, as appropriate, for additional assistance.

38 1399.835. When an individual submits a premium payment,
39 based on the quoted premium charges, and that payment is
40 delivered or postmarked, whichever occurs earlier, within the first

1 15 days of the month, coverage under the health plan contract shall
2 become effective no later than the first day of the following month.
3 When that payment is either delivered or postmarked after the 15th
4 day of a month, coverage shall become effective no later than the
5 first day of the second month following delivery or postmark of
6 the payment.

7 1399.836. Except as provided in Section 1399.829, a health
8 plan is not required to offer an individual health plan contract and
9 may reject an application for an individual health plan contract in
10 the case of any of the following:

11 (a) The individual and dependents who are to be covered by the
12 health plan contract do not work or reside in a health plan's
13 approved service area.

14 (b) (1) Within a specific service area or portion of a service
15 area, if a health plan reasonably anticipates and demonstrates to
16 the satisfaction of the director that it will not have sufficient health
17 care delivery resources to assure that health care services will be
18 available and accessible to the eligible individual and dependents
19 of the individual because of its obligations to existing enrollees.

20 (2) A health plan that cannot offer a health plan contract to
21 individuals because it is lacking in sufficient health care delivery
22 resources within a service area or a portion of a service area may
23 not offer a health plan contract in the area in which the health plan
24 is not offering coverage to individuals until the health plan notifies
25 the director that it has the ability to deliver services to new
26 enrollees, and certifies to the director that from the date of the
27 notice it will enroll all individuals and groups requesting coverage
28 in that area from the health plan.

29 (c) The plan is licensed in California and meets all of the
30 following criteria: (1) does not offer coverage to individuals in the
31 commercial market; (2) requires that its members qualify through
32 the Medicare Program or Medi-Cal program or their successors;
33 and (3) 75 percent or more of the organization's total enrollment
34 premiums are paid by the Medi-Cal program or Medicare Program,
35 or by a combination of Medi-Cal and Medicare payments. In no
36 event shall this exemption be based upon enrollment in Medicare
37 supplement contracts, as described in Article 3.5 (commencing
38 with Section 1358).

39 (d) Any person who has been a resident of California for six
40 months or less unless one of the following applies: (1) the person

1 is a federally eligible defined individual as defined in Section
2 1399.801 or Section 10785 of the Insurance Code, or (2) the person
3 can demonstrate a minimum of two years of prior creditable
4 coverage at least equivalent to the minimum creditable coverage
5 developed by the Managed Risk Medical Insurance Board pursuant
6 to Section 12739.50 of the Insurance Code and providing the
7 person applies for coverage in California within 62 days of
8 termination or cancellation of the prior creditable coverage.

9 (e) Any person who has been granted a temporary or permanent
10 hardship exemption from the requirement to maintain minimum
11 creditable coverage by the Managed Risk Medical Insurance Board
12 pursuant to Section 12739.501 of the Insurance Code during the
13 time period of the exemption as determined by the board.

14 1399.837. (a) If an individual disenrolls from a health plan
15 contract or health insurance policy or if the individual's health
16 plan contract or health insurance policy is canceled pursuant to
17 Section 1399.839 or Section 10936 of the Insurance Code prior to
18 the anniversary date of the health plan contract or health insurance
19 policy, subsequent enrollment in an individual health plan contract
20 or an individual health insurance policy shall be limited to the
21 same coverage choice category the individual was enrolled in prior
22 to disenrollment or cancellation.

23 (b) (1) An individual may change to a health plan contract in
24 a different coverage choice category only on the anniversary date
25 of the subscriber or upon a qualifying event.

26 (2) In no case, however, may an individual move up more than
27 one coverage choice category on the anniversary date of the
28 subscriber unless there is also a qualifying event.

29 (c) An individual health plan contract described in subdivision
30 (a) of Section 1399.826 that does not meet or exceed the
31 requirements for minimum creditable coverage established by the
32 Managed Risk Medical Insurance Board shall be deemed to be the
33 lowest coverage choice category for purposes of this section.

34 (d) On and after January 1, 2011, an individual who fails to
35 comply with the provisions of Chapter 15 (commencing with
36 Section 8899.50) of Division 1 of Title 2 of the Government Code
37 for more than 62 days may only enroll in a health plan contract or
38 health insurance policy in the lowest coverage choice category.
39 Upon the individual's anniversary date, the individual may move
40 to a higher coverage choice category pursuant to subdivision (b).

1 (e) For purposes of this section, a qualifying event occurs upon
2 any of the following:

3 (1) Upon the death of the subscriber, on whose qualifying
4 coverage an individual was a dependent.

5 (2) Upon marriage of the subscriber or entrance by the subscriber
6 into a domestic partnership pursuant to Section 298.5 of the Family
7 Code.

8 (3) Upon divorce or legal separation of an individual from the
9 subscriber.

10 (4) Upon loss of dependent status by a dependent enrolled in
11 group health care coverage through a health care service plan or
12 a health insurer.

13 (5) Upon the birth or adoption of a child.

14 (6) Upon the loss of minimum creditable coverage as defined
15 by the Managed Risk Medical Insurance Board pursuant to Section
16 12739.50 of the Insurance Code.

17 1399.838. The director may require a health plan to discontinue
18 the offering of contracts or acceptance of applications from any
19 individual upon a determination by the director that the health plan
20 does not have sufficient financial viability, or organizational and
21 administrative capacity to ensure the delivery of health care
22 services to its enrollees.

23 1399.839. (a) All health plan contracts offered pursuant to this
24 article shall be renewable with respect to all individuals and
25 dependents at the option of the subscriber and shall not be canceled
26 except for the following reasons:

27 (1) Failure to pay any charges for coverage provided pursuant
28 to the contract if the subscriber has been duly notified and billed
29 for those charges and at least 15 days has elapsed since the date
30 of notification.

31 (2) Fraud or intentional misrepresentation of material fact under
32 the terms of the health plan contract by the individual.

33 (3) Fraud or deception in the use of the services or facilities of
34 the plan or knowingly permitting that fraud or deception by
35 another.

36 (4) Movement of the subscriber outside the health plan's service
37 area.

38 (5) If the health plan ceases to provide or arrange for the
39 provision of health care services for new or existing individual

1 health plan contracts in this state, provided, however, that the
2 following conditions are satisfied:

3 (A) Notice of the decision to cease new or existing individual
4 health plan contracts in the state is provided to the director and to
5 the individual at least 180 days prior to discontinuation of that
6 coverage.

7 (B) Individual health plan contracts shall not be canceled for
8 180 days after the date of the notice required under subparagraph
9 (A) and for that business of a health plan that remains in force,
10 any health plan that ceases to offer for sale new individual health
11 plan contracts shall continue to be governed by this article with
12 respect to business conducted under this article.

13 (C) A health plan that ceases to write new individual health plan
14 contracts in this state after the effective date of this section shall
15 be prohibited from offering for sale individual health plan contracts
16 in this state for a period of five years from the date of notice to the
17 director. The director may permit a health plan to offer and sell
18 individual health plan contracts in this state before the five-year
19 time period has expired if the director determines that it is in the
20 best interest of the state and necessary to preserve the integrity of
21 the health care market.

22 (6) If the health plan withdraws an individual health plan
23 contract from the market, provided that the health plan notifies all
24 affected individuals and the director at least 90 days prior to the
25 discontinuation of these health plan contracts, and that the health
26 plan makes available to the individual all health plan contracts
27 with comparable benefits that it makes available to new individual
28 business.

29 (b) On or after July 1, 2010, a health plan shall not rescind the
30 health plan contract of any individual.

31 (c) Nothing in this article shall limit any other remedies available
32 at law to a health plan.

33 1399.840. Premiums for health plan contracts offered, renewed,
34 or delivered by health plans on or after the effective date of this
35 article shall be subject to the following requirements:

36 (a) The premium for new or existing business shall be the
37 standard risk rate for an individual in a particular risk category.

38 (b) The premium rates shall be in effect for no less than 12
39 months from the date of the health plan contract.

1 (c) When determining the premium rate for more than one
2 covered individual, the health plan shall determine the rate based
3 on the standard risk rate for the subscriber. If more than one
4 individual is a subscriber, the premium rate shall be based on the
5 age of the youngest spouse or registered domestic partner.

6 (d) (1) Notwithstanding subdivision (a), for the first two years
7 following the implementation of this section, a health plan may
8 apply a risk adjustment factor to the standard risk rate that may
9 not be more than 120 percent or less than 80 percent of the
10 applicable standard risk rate. In determining the risk adjustment
11 factor, a health plan shall use the standardized form and uniform
12 process developed by the director pursuant to subdivision (f).

13 (2) After the first two years following the implementation of
14 this section, the adjustments applicable under paragraph (1) shall
15 not be more than 110 percent or less than 90 percent of the standard
16 risk rate.

17 (3) Upon the renewal of any contract, the risk adjustment factor
18 applied to the individual's rate may not be more than 5 percentage
19 points different than the factor applied to that rate prior to renewal.
20 The same limitation shall be applied to individuals with respect to
21 the risk adjustment factor applicable for the purchase of a new
22 product where the individual's prior health plan has discontinued
23 that product.

24 (4) After the first four years following the implementation of
25 this section, a health plan shall base rates on the standard risk rate
26 with no risk adjustment factor.

27 (e) The director and the Insurance Commissioner shall jointly
28 establish a maximum limit on the ratio between the standard risk
29 rates for contracts for individuals in the 60 to 64 years of age,
30 inclusive, category and contracts for individuals in the 30 to 34
31 years of age, inclusive, category.

32 (f) On or before March 1, 2009, the director shall, in consultation
33 with the Insurance Commissioner and the Managed Risk Medical
34 Insurance Board and using a qualified independent actuary, develop
35 a standardized form and uniform evaluation process to be used by
36 all health care service plans and all disability insurers exclusively
37 for the purpose of determining any risk adjustment rating factor
38 to be applied to an individual's premium rate based on actual or
39 expected health care use. Health plans shall base the risk
40 adjustment factors as authorized in this section solely on the results

1 of the standardized form and uniform evaluation process developed
2 by the director.

3 1399.841. (a) In connection with the offering for sale of any
4 health plan contract to an individual, each health plan shall make
5 a reasonable disclosure, as part of its solicitation and sales
6 materials, of all of the following:

7 (1) The provisions concerning the health plan’s right to change
8 premium rates on an annual basis and the factors other than
9 provision of services experience that affect changes in premium
10 rates.

11 (2) Provisions relating to the guaranteed issue and renewal of
12 health plan contracts.

13 (3) Provisions relating to the individual’s right to obtain any
14 health plan contract the individual is eligible to enroll in pursuant
15 to Sections 1399.829 and 1399.837.

16 (4) The availability, upon request, of a listing of all the health
17 plan’s contracts, including the rates for each health plan contract.

18 (b) Every solicitor or solicitor firm contracting with one or more
19 health plans to solicit enrollments or subscriptions from individuals
20 shall, when providing information on health plan contracts to an
21 individual but making no specific recommendations on particular
22 health plan contracts, do both of the following:

23 (1) Advise the individual of the health plan’s obligation to sell
24 to any individual any health plan contract it offers to individuals
25 and provide him or her, upon request, with the actual rates that
26 would be charged to that individual for a given health plan contract.

27 (2) Notify the individual that the solicitor or solicitor firm will
28 procure rate and benefit information for the individual on any
29 health plan contract offered by a health plan whose contract the
30 solicitor sells.

31 (c) Prior to filing an application for a particular individual health
32 plan contract, the health plan shall obtain a signed statement from
33 the individual acknowledging that the individual has received the
34 disclosures required by this section.

35 1399.842. (a) At least 20 business days prior to offering a
36 health plan contract subject to this article, all health plans shall
37 file a notice of material modification with the director in
38 accordance with the provisions of Section 1352. The notice of
39 material modification shall include a statement certifying that the
40 health plan is in compliance with Sections 1399.821 and 1399.840.

1 The certified statement shall set forth the standard risk rate for
2 each risk category that will be used in setting the rates at which
3 the contract will be offered. Any action by the director, as permitted
4 under Section 1352, to disapprove, suspend, or postpone the health
5 plan's use of a health plan contract shall be in writing, specifying
6 the reasons that the health plan contract does not comply with the
7 requirements of this article.

8 (b) Prior to making any changes in the standard risk rates filed
9 with the director pursuant to subdivision (a), the health plan shall
10 file as an amendment a statement setting forth the changes and
11 certifying that the health plan is in compliance with Sections
12 1399.821 and 1399.840. If the standard risk rate is being changed,
13 a health plan may commence offering health plan contracts utilizing
14 the changed standard risk rate upon filing the certified statement
15 unless the director disapproves the amendment by written notice.

16 (c) Periodic changes to the standard risk rate that a health plan
17 proposes to implement over the course of up to 12 consecutive
18 months may be filed in conjunction with the certified statement
19 filed under subdivision (a) or (b).

20 (d) Each health plan shall maintain at its principal place of
21 business all of the information required to be filed with the director
22 pursuant to this article.

23 (e) This section shall become operative on July 1, 2009.

24 1399.843. (a) A health plan shall include all of the following
25 in the material modification notice filed pursuant to subdivision
26 (a) of Section 1399.842:

27 (1) A summary explanation of the following for each health
28 plan contract offered to individuals:

29 (A) Eligibility requirements.

30 (B) The full premium cost of each health plan contract in each
31 risk category, as defined in subdivision (k) of Section 1399.821.

32 (C) When and under what circumstances benefits cease.

33 (D) Other coverage that may be available if benefits under the
34 described health plan contract cease.

35 (E) The circumstances under which choice in the selection of
36 physicians and providers is permitted.

37 (F) Deductibles.

38 (G) Annual out-of-pocket maximums.

39 (2) A summary explanation of coverage for the following,
40 together with the corresponding copayments, coinsurance, and

1 applicable limitations for each health plan contract offered to
2 individuals:

- 3 (A) Professional services.
- 4 (B) Outpatient services.
- 5 (C) Preventive services.
- 6 (D) Hospitalization services.
- 7 (E) Emergency health coverage.
- 8 (F) Ambulance services.
- 9 (G) Prescription drug coverage.
- 10 (H) Durable medical equipment.
- 11 (I) Mental health and substance abuse services.
- 12 (J) Home health services.

13 (3) The telephone number or numbers that may be used by an
14 applicant to access a health plan customer service representative
15 to request additional information about the health plan contract.

16 (b) The department shall share the information provided by
17 health plans pursuant to this article with the Office of the Patient
18 Advocate for purposes of the development, creation, and
19 maintenance of the comparative benefits matrix.

20 1399.844. (a) The Director of the Department of Managed
21 Health Care shall, in consultation with the Insurance
22 Commissioner, an outside actuarial firm, and health plans and
23 insurers participating in the individual market, no later than July
24 1, 2010, develop and implement mechanisms to assist health plans
25 and health insurers in managing the risk of providing health
26 coverage in the individual market on a guarantee issue basis to the
27 extent that these mechanisms can improve access to individual
28 coverage.

29 (b) The mechanisms required under subdivision (a) shall include
30 methods for collecting information regarding the enrollment, prices,
31 rate variance, and any other information that may be required to
32 monitor the condition of the individual market, the risk exposure
33 of individual health plans and insurers, and to implement
34 subdivisions (c) and (d).

35 (c) (1) The mechanisms developed pursuant to subdivision (a)
36 shall include a method by which an assessment is made of the
37 health status risk mix of a plan’s guarantee issue products. To the
38 extent any plan’s risk mix is disproportionately high compared to
39 the overall risk mix of all enrollees in guarantee issue products in
40 the individual market, the mechanisms developed pursuant to

1 subdivision (a) shall include provisions designed to make
2 adjustments among plans and insurers based on the relative health
3 risk of individuals enrolled in different health plans and health
4 insurers. Methods to compensate for the relative health risk
5 assumed by health plans and insurers shall include the ability to
6 spread the costs to all health plan contracts and health insurance
7 policies in the individual market.

8 (2) The director and the commissioner shall jointly adopt
9 regulations identifying health plans and insurers that are required
10 to participate in the mechanisms established pursuant to this
11 subdivision.

12 (d) (1) The director and the commissioner shall also develop
13 as part of the mechanisms under subdivision (a) a method for the
14 provision of reinsurance for health plans or insurers offering
15 guarantee issue products in the individual market if the age adjusted
16 marketwide incidence of high-cost cases or high-risk categories
17 significantly exceed the incidence of those cases or categories
18 among enrollees of the California Cooperative Health Insurance
19 Purchasing Pool (Cal-CHIPP) who are ineligible for the Cal-CHIPP
20 Healthy Families plan. This reinsurance mechanism shall be based
21 on a uniform standard set of service payment levels based on a
22 methodology to be determined by the director and the
23 commissioner.

24 (2) This subdivision shall be implemented on July 1, 2010, or
25 the operative date of this section, whichever is later, and shall
26 continue to be implemented until one year after the implementation
27 of paragraph (4) of subdivision (d) of Section 1399.840.

28 (e) The director and the commissioner may contract with a
29 qualified actuarial firm or other entities to accomplish the
30 requirements of this section.

31 (f) No later than two years following implementation of
32 guarantee issue pursuant to Section 1399.829 and Section 10928
33 of the Insurance Code, the director and the commissioner shall
34 make a finding whether and to what extent the relative risk profile
35 of persons enrolled in individual coverage is higher than the risk
36 profile of those of specified Cal-CHIPP enrollees, based on data
37 following the first nine months of guarantee issue. If the risk profile
38 of those enrolled in individual coverage is more than 5 percent
39 higher than that of the specified Cal-CHIPP enrollees, the director
40 and the commissioner shall establish a reinsurance program for

1 individual market health plans and insurers to compensate for the
 2 adverse risk selection. ~~The costs of reinsurance pursuant to this~~
 3 ~~section in order to compensate for risk profile differentials of up~~
 4 ~~to 10 percent shall be funded by a broad-based assessment across~~
 5 ~~health care service plans and health insurers.~~ Funding to
 6 compensate for risk profile differentials exceeding 10 percent shall
 7 be paid by funds appropriated from the California Health Trust
 8 Fund.

9 1399.845. (a) The director may issue regulations that are
 10 necessary to carry out the purposes of this article.

11 (b) Nothing in this article shall be construed as providing the
 12 director with rate regulation authority.

13 1399.846. Sections 1399.823, 1399.826, and 1399.832 shall
 14 become operative on January 1, 2009, and Section 1399.842 shall
 15 become operative on July 1, 2009. The remaining sections in this
 16 article shall become operative on July 1, 2010.

17 SEC. 29. Article 1 (commencing with Section 104250) is added
 18 to Chapter 4 of Part 1 of Division 103 of the Health and Safety
 19 Code, to read:

20
 21 Article 1. California Diabetes Program

22
 23 104250. The State Department of Public Health shall maintain
 24 the California Diabetes Program, including, but not limited to, the
 25 following:

26 (a) Provide information on diabetes prevention and management
 27 to the public, including health care providers.

28 (b) Provide technical assistance to the Medi-Cal program,
 29 including participating providers and Medi-Cal managed care
 30 plans, regarding the proper scope of benefits to be provided to
 31 eligible individuals under Section 14137.10 of the Welfare and
 32 Institutions Code. The assistance may include, but shall not be
 33 limited to, all of the following:

34 (1) Provide information on evidence-based screening guidelines,
 35 tools, and protocols, including the distribution of these guidelines,
 36 tools, and protocols.

37 (2) Develop, with assistance from the State Department of
 38 Health Care Services, the Comprehensive Diabetes Services
 39 Program operational screening guidelines and protocols, utilizing

1 the most current American Diabetes Association screening criteria
2 for diabetes testing in adults.

3 (3) Provide the Comprehensive Diabetes Services Program
4 operational screening guidelines, tools, and protocols, including
5 the distribution of those guidelines, tools, and protocols.

6 (4) Provide screening service criteria for diabetes and
7 prediabetes in accordance with the guidelines developed for the
8 Comprehensive Diabetes Services Program.

9 (5) Provide information regarding culturally and linguistically
10 appropriate lifestyle coaching and self-management training for
11 eligible adults with prediabetes and diabetes, in accordance with
12 evidence-based interventions to avoid unhealthy blood sugar levels
13 that contribute to the progression of diabetes and its complications.

14 (c) Provide technical assistance to the State Department of
15 Health Care Services, including assistance on data collection and
16 evaluation of the Medi-Cal program's Comprehensive Diabetes
17 Services Program, established pursuant to Section 14137.10 of the
18 Welfare and Institutions Code.

19 (d) This section shall be implemented only to the extent funds
20 are appropriated for purposes of this section in the annual Budget
21 Act or in another statute.

22 SEC. 30. Section 104376 is added to the Health and Safety
23 Code, to read:

24 104376. (a) (1) The department, in consultation with the
25 Department of Managed Health Care, the State Department of
26 Health Care Services, the Managed Risk Medical Insurance Board,
27 and the Department of Insurance, shall annually identify, on the
28 basis of the number of persons insured, the 10 largest providers
29 of health care coverage, including both public and private entities,
30 and ascertain the smoking cessation benefits provided by each of
31 these coverage providers.

32 (2) The department shall summarize the smoking cessation
33 benefit information gathered under this subdivision and make the
34 benefit summary available on the Internet, including the
35 department's Web site.

36 (b) The department shall, where appropriate, include the
37 smoking cessation benefit information as part of its educational
38 efforts to prevent tobacco use that it renders to the public and to
39 health care providers.

1 (c) The department shall conduct an evaluation, commencing
2 one year following the publication of the smoking cessation benefit
3 information on the department’s Web site as provided in this
4 section, to assess all of the following:

5 (1) Any changes in the awareness of the beneficiaries of the 10
6 largest providers of health care coverage as to the availability of
7 smoking cessation benefits.

8 (2) Any changes in the awareness of health care providers as to
9 the availability of smoking cessation benefits.

10 (3) The extent to which smoking cessation benefits are utilized
11 by beneficiaries of the 10 largest providers of health care coverage,
12 and any changes in the utilization rate of these benefits as
13 determined by a comparison with any available preexisting
14 information.

15 (4) Smoking-related indicators available through the Health
16 Plan Employer Data and Information Set.

17 (5) Any changes to the smoking cessation benefit coverage of
18 the 10 largest providers of health care coverage.

19 (6) The impact on smoking rates based on the expansion of
20 counseling services and the direct provision of tobacco cessation
21 pharmacotherapy by the California Smokers’ Helpline.

22 (d) To the extent funds are appropriated for these purposes, the
23 department shall increase its efforts to do all of the following:

24 (1) Reduce smoking by increasing the capacity of effective
25 cessation services available from the California Smokers’ Helpline,
26 including tobacco cessation pharmacotherapy.

27 (2) Expand public awareness about the services that are available
28 through the California Smokers’ Helpline.

29 (3) Expand public awareness and use of existing cessation
30 benefits that are available to California smokers through their
31 public and private providers of health care coverage.

32 SEC. 31. Article 3 (commencing with Section 104705) is added
33 to Chapter 2 of Part 3 of Division 103 of the Health and Safety
34 Code, to read:

35

36 Article 3. Community Makeover Grants

37

38 104705. (a) The Community Makeover Grant program is
39 hereby created and shall be administered by the department. The

1 department shall award grants to local health departments to serve
2 as local lead agencies in accordance with this article.

3 (b) For purposes of determining the amount of each grant
4 awarded under this article, local health departments shall be
5 allocated, at a minimum, base funding in proportion to total
6 available funding.

7 (c) Except as provided in subdivision (b), local health
8 departments shall receive an allocation based on each county's or
9 city's proportion of the statewide population, to be expended for
10 purposes that include, but need not be limited to:

11 (1) Creating a community infrastructure that promotes active
12 living and healthy eating.

13 (2) Coordinating with, at minimum, city, county, and school
14 partners to facilitate community level, multisector collaboration
15 for the development and implementation of strategies to facilitate
16 active living and healthy eating.

17 (3) Conducting competitive grant application processes to
18 support local grants. These local grants may be used to develop
19 new programs and improve existing programs to promote physical
20 activity for children, improve access to healthy foods, and better
21 utilize community recreation facilities.

22 (4) Preparing program interventions and materials that will be
23 available in accessible, and culturally and linguistically appropriate,
24 formats.

25 (d) The department shall issue guidelines for local lead agencies
26 on how to prepare a local plan for a comprehensive community
27 intervention program that includes changes to promote active living
28 and healthy eating, and to prevent obesity and other related chronic
29 diseases.

30 (e) The department shall specify data reporting requirements
31 for local lead agencies and their subcontractors.

32 (f) (1) The department shall conduct a fiscal and program
33 review on a regular basis.

34 (2) If the department determines that any local lead agency is
35 not in compliance with any provision of this article, the local lead
36 agency shall submit to the department, within 60 days, a plan for
37 complying with this article.

38 (3) The department may withhold funds allocated under this
39 section from local lead agencies that are not in compliance with
40 this article.

1 (g) For purposes of this article, “department” means the State
2 Department of Public Health.

3 104710. (a) The department may provide a variety of training,
4 consultation, and technical assistance to support local programs.

5 (b) Notwithstanding any other provision of law, the department
6 may use a request for proposal process or may directly award
7 contracts to provide the assistance described in subdivision (a) to
8 another state, federal, or auxiliary organization.

9 (c) Any organization awarded a contract under this section shall
10 demonstrate the ability to provide statewide assistance to accelerate
11 progress, and to ensure the long-term impact of local obesity
12 prevention programs.

13 104715. (a) The department shall track and evaluate
14 obesity-related measures, including, but not limited to, active
15 living, healthy eating, and community environment indicators.
16 These tracking and evaluation activities shall utilize scientifically
17 appropriate methods, and may include, but need not be limited to,
18 the following:

- 19 (1) Track statewide health indicators.
- 20 (2) Evaluate funded projects, determining baseline measures
21 and progress toward goals, as well as capturing successes and
22 emerging models.
- 23 (3) Compare the effectiveness of individual programs to inform
24 funding decisions and program modifications.
- 25 (4) Incorporate other aspects into the evaluation that have been
26 identified by the department in consultation with state and local
27 advisory groups, local health departments, and other interested
28 parties.
- 29 (5) Forecast health and economic cost consequences associated
30 with obesity.
- 31 (6) Funds permitting, utilize a sample size that is adequate to
32 produce county-, ethnic-, and disability-specific estimates.

33 (b) The purpose of the evaluation shall be to direct the most
34 efficient allocation of resources appropriated under this article to
35 accomplish the maximum reduction of obesity rates. The
36 comprehensive evaluation shall be designed to measure the extent
37 to which programs funded pursuant to this article promote the
38 goals identified in the California Obesity Prevention Plan.

39 104720. The department shall develop a campaign to educate
40 the public about the importance of obesity prevention that frames

1 active living and healthy eating as “California living.” The
2 campaign-centered efforts shall be closely linked with
3 community-level program change efforts and shall be available in
4 accessible and culturally and linguistically appropriate formats.

5 104721. The department shall provide assistance and other
6 support for schools to promote the availability and consumption
7 of fresh fruits and vegetables and foods with whole grains.

8 104725. The department shall provide technical assistance to
9 help employers integrate wellness policies and programs into
10 employee benefit plans and worksites.

11 104726. Notwithstanding any other provision of law, this article
12 shall be implemented only to the extent funds are appropriated for
13 purposes of this article in the annual Budget Act or in another
14 statute.

15 SEC. 31.1. Section 124900 of the Health and Safety Code is
16 amended to read:

17 124900. (a) (1) The State Department of Health Care Services
18 shall select primary care clinics that are licensed under paragraph
19 (1) or (2) of subdivision (a) of Section 1204, or are exempt from
20 licensure under subdivision (c) of Section 1206, to be reimbursed
21 for delivering medical services, including preventive health care,
22 and smoking prevention and cessation health education, to program
23 beneficiaries.

24 (2) In order to be eligible to receive funds under this article a
25 clinic shall meet all of the following conditions, at a minimum:

26 (A) Provide medical diagnosis and treatment.

27 (B) Provide medical support services of patients in all stages of
28 illness.

29 (C) Provide communication of information about diagnosis,
30 treatment, prevention, and prognosis.

31 (D) Provide maintenance of patients with chronic illness.

32 (E) Provide prevention of disability and disease through
33 detection, education, persuasion, and preventive treatment.

34 (F) Meet one or both of the following conditions:

35 (i) Are located in an area or a facility federally designated as a
36 health professional shortage area, medically underserved area, or
37 medically underserved population.

38 (ii) Are clinics that are able to demonstrate that at least 50
39 percent of the patients served are persons with incomes at or below
40 250 percent of the federal poverty level.

1 (G) Serve as a designated primary care medical home for
2 program beneficiaries, as described in subdivision (c) of Section
3 124905.

4 (3) Notwithstanding the requirements of paragraph (2), all clinics
5 that received funds under this article in the 1997–98 fiscal year
6 shall continue to be eligible to receive funds under this article.

7 (b) As a part of the award process for funding pursuant to this
8 article, the department shall take into account the availability of
9 primary care services in the various geographic areas of the state.
10 The department shall determine which areas within the state have
11 populations which have clear and compelling difficulty in obtaining
12 access to primary care. The department shall consider proposals
13 from new and existing eligible providers to extend clinic services
14 to these populations.

15 (c) Each primary care clinic applying for funds pursuant to this
16 article shall demonstrate that the funds shall be used to expand
17 medical services, including preventive health care, and smoking
18 prevention and cessation health education, for program
19 beneficiaries above the level of services provided in the 1988
20 calendar year or in the year prior to the first year a clinic receives
21 funds under this article if the clinic did not receive funds in the
22 1989 calendar year.

23 (d) (1) The department, in consultation with clinics funded
24 under this article, shall develop a formula for allocation of funds
25 available. It is the intent of the Legislature that the funds allocated
26 pursuant to this article promote stability for those clinics
27 participating in programs under this article as part of the state’s
28 health care safety net and at the same time be distributed in a
29 manner that best promotes access to health care to uninsured
30 populations.

31 (2) The formula shall be based on both of the following:

32 (A) A hold harmless for clinics funded in the 1997–98 fiscal
33 year to continue to reimburse them for some portion of their
34 uncompensated care.

35 (B) Demonstrated unmet need by both new and existing clinics,
36 as reflected in their levels of uncompensated care reported to the
37 department. For purposes of this article, “uncompensated care”
38 means clinic patient visits for persons with incomes at or below
39 250 percent of the federal poverty level for which there is no

1 encounter-based third-party reimbursement which includes, but is
2 not limited to, unpaid expanded access to primary care claims.

3 (3) The department shall allocate available funds, for a
4 three-year period, as follows:

5 (A) Clinics that received funding in the prior fiscal year shall
6 receive 90 percent of their prior fiscal year allocation, subject to
7 available funds, provided that the funding award is substantiated
8 by the clinics' reported levels of uncompensated care.

9 (B) The remaining funds beyond 90 percent shall be awarded
10 to new and existing applicants based on the clinics' reported levels
11 of uncompensated care as verified by the department according to
12 subparagraph (B) of paragraph (4). The department shall seek input
13 from stakeholders to discuss any adjustments to award levels that
14 the department deems reasonable, such as including base amounts
15 for new applicant clinics.

16 (C) New applicants shall be awarded funds pursuant to this
17 subdivision if they meet the minimum requirements for funding
18 under this article based on the clinics' reported levels of
19 uncompensated care as verified by the department according to
20 subparagraph (A) of paragraph (4). New applicants include
21 applicants for any new site expansions by existing applicants.

22 (4) In assessing reported levels of uncompensated care, the
23 department shall utilize the data available from the Office of
24 Statewide Health Planning and Development's (OSHPD)
25 completed analysis of the "Annual Report of Primary Care Clinics"
26 for the prior fiscal year, or if more recent data is available, then
27 the most recent data. If this data is unavailable for an existing
28 applicant to assess reported levels of uncompensated care, the
29 existing applicant shall receive an allocation pursuant to
30 subparagraph (A) of paragraph (3).

31 (A) The department shall utilize the most recent data available
32 from OSHPD's completed analysis of the "Annual Report of
33 Primary Care Clinics" for the prior fiscal year, or if more recent
34 data is available, then the most recent data.

35 (B) If the funds allocated to the program are less than the prior
36 year, the department shall allocate available funds to existing
37 program providers only.

38 (5) The department shall establish a base funding level, subject
39 to available funds, of no less than thirty-five thousand dollars
40 (\$35,000) for frontier clinics and Native American

1 reservation-based clinics. For purposes of this article, “frontier
2 clinics” means clinics located in a medical services study area with
3 a population of fewer than 11 persons per square mile.

4 (6) The department shall develop, in consultation with clinics
5 funded pursuant to this article, a formula for reallocation of unused
6 funds to other participating clinics to reimburse for uncompensated
7 care. The department shall allocate the unused funds remaining
8 on October 30, for the prior fiscal year to other participating clinics
9 to reimburse for uncompensated care.

10 (e) In applying for funds, eligible clinics shall submit a single
11 application per clinic corporation. Applicants with multiple sites
12 shall apply for all eligible clinics, and shall report to the department
13 the allocation of funds among their corporate sites in the prior
14 year. A corporation may only claim reimbursement for services
15 provided at a program-eligible clinic site identified in the corporate
16 entity’s application for funds, and approved for funding by the
17 department. A corporation may increase or decrease the number
18 of its program-eligible clinic sites on an annual basis, at the time
19 of the annual application update for the subsequent fiscal years of
20 any multiple-year application period.

21 (f) Grant allocations pursuant to this article shall be based on
22 the formula developed by the department, notwithstanding a merger
23 of one or more licensed primary care clinics participating in the
24 program.

25 (g) A clinic that is eligible for the program in every other
26 respect, but that provides dental services only, rather than the full
27 range of primary care medical services, shall only be eligible to
28 receive funds under this article on an exception basis. A dental-only
29 provider’s application shall include a memorandum of
30 understanding (MOU) with a primary care clinic funded under this
31 article. The MOU shall include medical protocols for making
32 referrals by the primary care clinic to the dental clinic and from
33 the dental clinic to the primary care clinic, and ensure that case
34 management services are provided and that the patient is being
35 provided comprehensive primary care as defined in subdivision
36 (a).

37 (h) (1) For purposes of this article, an outpatient visit shall
38 include diagnosis and medical treatment services, including the
39 associated pharmacy, X-ray, and laboratory services, and
40 prevention health and case management services that are needed

1 as a result of the outpatient visit. For a new patient, an outpatient
2 visit shall also include a health assessment encompassing an
3 assessment of smoking behavior and the patient’s need for
4 appropriate health education specific to related tobacco use and
5 exposure.

6 (2) “Case management” includes, for this purpose, the
7 management of all physician services, both primary and specialty,
8 and arrangements for hospitalization, postdischarge care, and
9 followup care.

10 (i) (1) Payment shall be on a per-visit basis at a rate that is
11 determined by the department to be appropriate for an outpatient
12 visit as defined in this section, and shall be not less than
13 seventy-one dollars and fifty cents (\$71.50).

14 (2) In developing a statewide uniform rate for an outpatient visit
15 as defined in this article, the department shall consider existing
16 rates of payments for comparable outpatient visits. The department
17 shall review the outpatient visit rate on an annual basis.

18 (j) Not later than June 1 of each year, the department shall adopt
19 and provide each licensed primary care clinic with a schedule for
20 programs under this article, including the date for notification of
21 availability of funds, the deadline for the submission of a completed
22 application, and an anticipated contract award date for successful
23 applicants.

24 (k) In administering the program created pursuant to this article,
25 the department shall utilize the Medi-Cal program statutes and
26 regulations pertaining to program participation standards, medical
27 and administrative recordkeeping, the ability of the department to
28 monitor and audit clinic records pertaining to program services
29 rendered to program beneficiaries and take recoupments or
30 recovery actions consistent with monitoring and audit findings,
31 and the provider’s appeal rights. Each primary care clinic applying
32 for program participation shall certify that it will abide by these
33 statutes and regulations and other program requirements set forth
34 in this article.

35 SEC. 31.2. Section 124905 of the Health and Safety Code is
36 amended to read:

37 124905. (a) For purposes of this article, a “program
38 beneficiary” is a person whose income level is at or below 250
39 percent of the federal poverty level, as adjusted annually, and who
40 meets one of the following requirements:

1 (1) Does not currently have private or employer-based health
2 care coverage.

3 (2) Is not currently enrolled in or does not qualify for public
4 health care coverage programs, including, but not limited to, full
5 scope Medi-Cal, the Healthy Families Program, the benefits
6 package made available under Section 14005.333 of the Welfare
7 and Institutions Code, subsidized coverage provided by the
8 Managed Risk Medical Insurance Board pursuant to Part 6.45
9 (commencing with section 12699.201) of Division 2 of the
10 Insurance Code, or coverage made available through the Major
11 Risk Medical Insurance Program pursuant to Part 6.5 (commencing
12 with section 12700) of Division 2 of the Insurance Code.

13 (b) Program beneficiaries shall not be required to provide any
14 copayment for services that are funded pursuant to this article,
15 except that clinics may charge beneficiaries on a sliding fee scale
16 for services, but no beneficiary shall be denied services because
17 of an inability to pay. The department shall annually adjust this
18 income standard to reflect any changes in the federal poverty level.
19 Payment pursuant to this article shall be made only for services
20 for which payment will not be made through any private or public
21 third-party reimbursement.

22 (c) In order to ensure that a program beneficiary has access to
23 appropriate preventive and primary care, the beneficiary shall
24 choose a designated primary care medical home with a primary
25 care provider that shall maintain all of that beneficiary’s medical
26 information.

27 (d) In order to readily access program benefits, a program
28 beneficiary shall be issued a primary care card pursuant to Section
29 124905.1 upon the determination of eligibility.

30 (e) The period of eligibility under this section shall extend for
31 a one-year period from the date that eligibility is established. If
32 the program beneficiary experiences a change in circumstances
33 which would impact his or her eligibility, the beneficiary shall
34 report that change within 10 days of its occurrence.

35 SEC. 31.3. Section 124905.1 is added to the Health and Safety
36 Code, to read:

37 124905.1. On or before July 1, 2010, the department shall
38 develop an electronic system to perform all of the following
39 functions:

1 (a) Provide an eligibility application for primary clinic services
2 made available to program beneficiaries under this article. That
3 application shall request all information necessary to determine
4 eligibility for those services.

5 (b) Verify annual income of applicants.

6 (c) Issue a primary care clinic card to an applicant who is
7 determined eligible for services under this article.

8 SEC. 31.4. Section 124910 of the Health and Safety Code is
9 amended to read:

10 124910. (a) (1) Each licensed primary care clinic, as specified
11 in subdivision (a) of Section 124900, applying for funds under this
12 article, shall demonstrate in its application that it meets all of the
13 following conditions, at a minimum:

14 (A) Provides medical diagnosis and treatment.

15 (B) Provides medical support services of patients in all stages
16 of illness.

17 (C) Provides communication of information about diagnosis,
18 treatment, prevention, and prognosis.

19 (D) Provides maintenance of patients with chronic illness.

20 (E) Provides prevention of disability and disease through
21 detection, education, persuasion, and preventive treatment.

22 (F) Meets one or both of the following conditions:

23 (i) Is located in an area or a facility federally designated as a
24 health professional shortage area, medically underserved area, or
25 medically underserved population.

26 (ii) Is a clinic in which at least 50 percent of the patients served
27 are persons with incomes at or below 250 percent of the federal
28 poverty level.

29 (2) Any applicant who has applied for and received a federal
30 or state designation for serving a health professional shortage area,
31 medically underserved area, or population shall be deemed to meet
32 the requirements of subdivision (a) of Section 124900.

33 (b) Each applicant shall also demonstrate to the satisfaction of
34 the department that the proposed services supplement, and do not
35 supplant, those primary care services to program beneficiaries that
36 are funded by any county, state, or federal program.

37 (c) Each applicant shall demonstrate that it is an active Medi-Cal
38 provider by being enrolled in Medi-Cal and diligently billing the
39 Medi-Cal program for services rendered to Medi-Cal eligible
40 patients during the past three months prior to the application due

1 date. This subdivision shall not apply to clinics that are not
2 currently Medi-Cal providers, and were funded participants
3 pursuant to this article during the 1993–94 fiscal year.

4 (d) Each application shall be evaluated by the state department
5 prior to funding to determine all of the following:

6 (1) The applicant shall provide its most recently audited financial
7 statement to verify budget information.

8 (2) The applicant’s ability to deliver basic primary care to
9 program beneficiaries.

10 (3) A description of the applicant’s operational quality assurance
11 program.

12 (4) The applicant’s use of protocols for the most common
13 diseases in the population served under this article.

14 SEC. 31.5. Section 124920 of the Health and Safety Code is
15 amended to read:

16 124920. (a) In order to implement this section, the department
17 may contract with public or private entities or utilize existing health
18 care service provider enrollment and payment mechanisms,
19 including the fiscal intermediary of the Medi-Cal program.

20 (b) The department shall certify which primary care clinics are
21 selected to participate in the program for each specific fiscal year,
22 and how much in program funds each selected primary care clinic
23 will be allocated each fiscal year.

24 (c) The department shall pay claims from selected primary care
25 clinics up to each clinic’s annual allocation. Once a clinic has
26 exhausted its annual allocation, the state shall stop paying its
27 program claims.

28 (d) The department may adjust any selected primary care clinic’s
29 allocation to take into account:

30 (1) An increase in program funds appropriated for the fiscal
31 year.

32 (2) A decrease in program funds appropriated for the fiscal year.

33 (3) A clinic’s projected inability to fully spend its allocation
34 within the fiscal year.

35 (4) Surplus funds reallocated from other selected primary care
36 clinics.

37 (e) The department shall notify all affected primary care clinics
38 in writing prior to adjusting selected primary care clinics’
39 allocations.

1 (f) Cessation of program payments under subdivision (e) or
 2 adjustment of selected primary care clinic’s allocations under
 3 subdivision (d) shall not be subject to the Medi-Cal appeals process
 4 referenced in subdivision (g) of Section 124900.

5 (g) A clinic’s allocation under this article shall not be reduced
 6 solely because the clinic has engaged in supplemental fundraising
 7 drives and activities, the proceeds of which have been used to
 8 defray the costs of services to the uninsured.

9 SEC. 31.6. Section 124946 is added to the Health and Safety
 10 Code, to read:

11 124946. The department shall seek to maximize the availability
 12 of federal funding for services provided pursuant to this article
 13 under the terms of any existing waiver, through amendment of any
 14 existing waiver, or by means of a new waiver, or any combination
 15 thereof.

16 SEC. 32. Section 128745 of the Health and Safety Code is
 17 amended to read:

18 128745. (a) Commencing July 1993, and annually thereafter,
 19 the office shall publish risk-adjusted outcome reports in accordance
 20 with the following schedule:

21

22	Publication	Period	Procedures and
23	Date	Covered	Conditions
24			Covered
25	July 1993	1988–90	3
26	July 1994	1989–91	6
27	July 1995	1990–92	9

28

29 Reports for subsequent years shall include conditions and
 30 procedures and cover periods as appropriate.

31 (b) The procedures and conditions required to be reported under
 32 this chapter shall be divided among medical, surgical, and obstetric
 33 conditions or procedures and shall be selected by the office, based
 34 on the recommendations of the commission and the advice of the
 35 technical advisory committee set forth in subdivision (j) of Section
 36 128725. The office shall publish the risk-adjusted outcome reports
 37 for surgical procedures by individual hospital and individual
 38 surgeon unless the office in consultation with the technical advisory
 39 committee and medical specialists in the relevant area of practice
 40 determines that it is not appropriate to report by individual surgeon.

1 The office, in consultation with the technical advisory committee
2 and medical specialists in the relevant area of practice, may decide
3 to report nonsurgical procedures and conditions by individual
4 physician when it is appropriate. The selections shall be in
5 accordance with all of the following criteria:

6 (1) The patient discharge abstract contains sufficient data to
7 undertake a valid risk adjustment. The risk adjustment report shall
8 ensure that public hospitals and other hospitals serving primarily
9 low-income patients are not unfairly discriminated against.

10 (2) The relative importance of the procedure and condition in
11 terms of the cost of cases and the number of cases and the
12 seriousness of the health consequences of the procedure or
13 condition.

14 (3) Ability to measure outcome and the likelihood that care
15 influences outcome.

16 (4) Reliability of the diagnostic and procedure data.

17 (c) (1) In addition to any other established and pending reports,
18 on or before July 1, 2002, the office shall publish a risk-adjusted
19 outcome report for coronary artery bypass graft surgery by hospital
20 for all hospitals opting to participate in the report. This report shall
21 be updated on or before July 1, 2003.

22 (2) In addition to any other established and pending reports,
23 commencing July 1, 2004, and every year thereafter, the office
24 shall publish risk-adjusted outcome reports for coronary artery
25 bypass graft surgery for all coronary artery bypass graft surgeries
26 performed in the state. In each year, the reports shall compare
27 risk-adjusted outcomes by hospital, and in every other year, by
28 hospital and cardiac surgeon. Upon the recommendation of the
29 technical advisory committee based on statistical and technical
30 considerations, information on individual hospitals and surgeons
31 may be excluded from the reports.

32 (3) Unless otherwise recommended by the clinical panel
33 established by Section 128748, the office shall collect the same
34 data used for the most recent risk-adjusted model developed for
35 the California Coronary Artery Bypass Graft Mortality Reporting
36 Program. Upon recommendation of the clinical panel, the office
37 may add any clinical data elements included in the Society of
38 Thoracic Surgeons' data base. Prior to any additions from the
39 Society of Thoracic Surgeons' data base, the following factors
40 shall be considered:

1 (A) Utilization of sampling to the maximum extent possible.

2 (B) Exchange of data elements as opposed to addition of data
3 elements.

4 (4) Upon recommendation of the clinical panel, the office may
5 add, delete or revise clinical data elements, but shall add no more
6 than a net of six elements not included in the Society of Thoracic
7 Surgeons' data base, to the data set over any five-year period. Prior
8 to any additions or deletions, all of the following factors shall be
9 considered:

10 (A) Utilization of sampling to the maximum extent possible.

11 (B) Feasibility of collecting data elements.

12 (C) Costs and benefits of collection and submission of data.

13 (D) Exchange of data elements as opposed to addition of data
14 elements.

15 (5) The office shall collect the minimum data necessary for
16 purposes of testing or validating a risk-adjusted model for the
17 coronary artery bypass graft report.

18 (d) (1) In addition to any other established and pending reports,
19 commencing January 1, 2010, and every year thereafter, the office
20 shall publish risk-adjusted outcome reports for percutaneous
21 coronary interventions, including, but not limited to, the use of
22 angioplasty or stents. In each year, the reports shall compare
23 risk-adjusted outcomes by hospital, and in at least every other year,
24 by hospital and physician. Upon the recommendation of the
25 technical advisory committee based on statistical and technical
26 considerations, information on individual hospitals and surgeons
27 may be excluded from the reports.

28 (2) The office shall establish a clinical data collection program
29 to collect data on percutaneous coronary interventions, including,
30 but not limited to, the use of angioplasty or stents, performed in
31 hospitals. Based upon the recommendation of the clinical advisory
32 panel established pursuant to Section 128748, the office shall
33 establish by regulation the data to be reported by each hospital at
34 which percutaneous coronary interventions are performed.

35 (3) When establishing the clinical data collection program to
36 collect data on percutaneous coronary interventions, the office
37 shall consider all of the following factors:

38 (A) Utilization of sampling to the maximum extent possible.

39 (B) Feasibility of collecting data elements.

40 (C) Costs and benefits of collection and submission of data.

1 (D) Exchange of data elements as opposed to addition of data
2 elements.

3 (4) The office shall collect the minimum data necessary for
4 purposes of testing or validating a risk-adjusted model for the
5 percutaneous coronary intervention report.

6 (e) The annual reports shall compare the risk-adjusted outcomes
7 experienced by all patients treated for the selected conditions and
8 procedures in each California hospital during the period covered
9 by each report, to the outcomes expected. Outcomes shall be
10 reported in the five following groupings for each hospital:

11 (1) “Much higher than average outcomes,” for hospitals with
12 risk-adjusted outcomes much higher than the norm.

13 (2) “Higher than average outcomes,” for hospitals with
14 risk-adjusted outcomes higher than the norm.

15 (3) “Average outcomes,” for hospitals with average risk-adjusted
16 outcomes.

17 (4) “Lower than average outcomes,” for hospitals with
18 risk-adjusted outcomes lower than the norm.

19 (5) “Much lower than average outcomes,” for hospitals with
20 risk-adjusted outcomes much lower than the norm.

21 (f) For coronary artery bypass graft surgery reports and any
22 other outcome reports for which auditing is appropriate, the office
23 shall conduct periodic auditing of data at hospitals.

24 (g) The office shall publish in the annual reports required under
25 this section the risk-adjusted mortality rate for each hospital and
26 for those reports that include physician reporting, for each
27 physician.

28 (h) The office shall either include in the annual reports required
29 under this section, or make separately available at cost to any
30 person requesting it, risk-adjusted outcomes data assessing the
31 statistical significance of hospital or physician data at each of the
32 following three levels: 99 percent confidence level (0.01 p-value),
33 95 percent confidence level (0.05 p-value), and 90 percent
34 confidence level (0.10 p-value). The office shall include any other
35 analysis or comparisons of the data in the annual reports required
36 under this section that the office deems appropriate to further the
37 purposes of this chapter.

38 SEC. 32.5. Section 128748 of the Health and Safety Code is
39 amended to read:

1 128748. (a) This section shall apply to any risk-adjusted
2 outcome report that includes reporting of data by an individual
3 physician.

4 (b) (1) The office shall obtain data necessary to complete a
5 risk-adjusted outcome report from hospitals. If necessary data for
6 an outcome report is available only from the office of a physician
7 and not the hospital where the patient received treatment, then the
8 hospital shall make a reasonable effort to obtain the data from the
9 physician's office and provide the data to the office. In the event
10 that the office finds any errors, omissions, discrepancies, or other
11 problems with submitted data, the office shall contact either the
12 hospital or physician's office that maintains the data to resolve the
13 problems.

14 (2) The office shall collect the minimum data necessary for
15 purposes of testing or validating a risk-adjusted model. Except for
16 data collected for purposes of testing or validating a risk-adjusted
17 model, the office shall not collect data for an outcome report nor
18 issue an outcome report until the clinical panel established pursuant
19 to this section has approved the risk-adjusted model.

20 (c) For each risk-adjusted outcome report on a medical, surgical,
21 or obstetric condition or procedure that includes reporting of data
22 by an individual physician, the office director shall appoint a
23 clinical panel, which shall have nine members. Three members
24 shall be appointed from a list of three or more names submitted
25 by the physician specialty society that most represents physicians
26 performing the medical, surgical, and obstetric procedure for which
27 data is collected. Three members shall be appointed from a list of
28 three or more names submitted by the California Medical
29 Association. Three members shall be appointed from lists of names
30 submitted by consumer organizations. At least one-half of the
31 appointees from the lists submitted by the physician specialty
32 society and the California Medical Association, and at least one
33 appointee from the lists submitted by consumer organizations,
34 shall be experts in collecting and reporting outcome measurements
35 for physicians or hospitals. The panel may include physicians from
36 another state. The panel shall review and approve the development
37 of the risk-adjustment model to be used in preparation of the
38 outcome report.

39 (d) For the clinical panels authorized by subdivision (c) for
40 coronary artery bypass graft surgery and percutaneous coronary

1 intervention, three members shall be appointed from a list of three
 2 or more names submitted by the California Chapter of the
 3 American College of Cardiology. Three members shall be
 4 appointed from list of three or more names submitted by the
 5 California Medical Association. Three members shall be appointed
 6 from lists of names submitted by consumer organizations. At least
 7 one-half of the appointees from the lists submitted by the California
 8 Chapter of the American College of Cardiology, and the California
 9 Medical Association, and at least one appointee from the lists
 10 submitted by consumer organizations, shall be experts in collecting
 11 and reporting outcome measurements for physicians and surgeons
 12 or hospitals. The panels may include physicians from another state.
 13 The panels shall review and approve the development of the
 14 risk-adjustment model to be used in preparation of the outcome
 15 report.

16 (e) Any report that includes reporting by an individual physician
 17 shall include, at a minimum, the risk-adjusted outcome data for
 18 each physician. The office may also include in the report, after
 19 consultation with the clinical panel, any explanatory material,
 20 comparisons, groupings, and other information to facilitate
 21 consumer comprehension of the data.

22 (f) Members of a clinical panel shall serve without
 23 compensation, but shall be reimbursed for any actual and necessary
 24 expenses incurred in connection with their duties as members of
 25 the clinical panel.

26 SEC. 33. Chapter 4 (commencing with Section 128850) is
 27 added to Part 5 of Division 107 of the Health and Safety Code, to
 28 read:

29
 30 CHAPTER 4. HEALTH CARE COST AND QUALITY TRANSPARENCY

31
 32 Article 1. General Provisions

33
 34 128850. The Legislature hereby finds and declares all of the
 35 following:

36 (a) The steady rise in health costs is eroding health access,
 37 straining public health and finance systems, and placing an undue
 38 burden on the state’s economy.

39 (b) The effective use and distribution of health care data and
 40 meaningful analysis of that data will lead to greater transparency

1 in the health care system resulting in improved health care quality
2 and outcomes, more cost-effective care, improvements in life
3 expectancy, reduced preventable deaths, and improved overall
4 public health.

5 (c) Hospitals, physicians, health care providers, and health
6 insurers who have access to systemwide performance data can be
7 called upon to use the information to improve patient safety,
8 efficiency of health care delivery, and quality of care, leading to
9 quality improvement and costs savings throughout the health care
10 system.

11 (d) The State of California is uniquely positioned to collect,
12 analyze, and report data on health care utilization, quality, and
13 costs in the state in order to facilitate value-based purchasing of
14 health care and to support and promote continuous quality
15 improvement among health plans and providers.

16 (e) Establishing statewide data and common measurement and
17 analysis of health care costs, quality, and outcomes will identify
18 appropriate health care utilization and ensure the highest quality
19 of health care services for all Californians.

20 (f) Comprehensive statewide data and common measurement
21 will allow analysis on the provision of care so that efforts can be
22 undertaken to improve health outcomes for all Californians,
23 including those groups with demonstrated health disparities.

24 (g) It is therefore the intent of the Legislature that the State of
25 California assume a leadership role in measuring performance and
26 value in the health care system. By establishing the primary
27 statewide data and common measurement and analyses of health
28 care costs, quality, and outcomes, and by providing sufficient
29 revenues to adequately analyze and report meaningful performance
30 measures related to health care costs, safety, and quality, the
31 Legislature intends to promote competition, identify appropriate
32 health care utilization, and ensure the highest quality of health care
33 services for all Californians.

34 (h) The Legislature further intends to reduce duplication and
35 inconsistency in the collection, analysis, and dissemination of
36 health care performance information within state government and
37 among both public and private entities by coordinating health care
38 data development, collection, analysis, evaluation, and
39 dissemination.

1 (i) It is further the intent of the Legislature that the data collected
2 be used for the transparent public reporting of quality and cost
3 efficiency information regarding all levels of the health care
4 system, including health care service plans and health insurers,
5 hospitals and other health facilities, and medical groups, physicians,
6 and other licensed health professionals in independent practice,
7 so that health care plans and providers can improve their
8 performance and deliver safer, better health care more affordably;
9 so that purchasers can know which health care services reduce
10 morbidity, mortality, and other adverse health outcomes; so that
11 consumers can choose whether and where to have health care
12 provided; and so that policymakers can effectively monitor the
13 health care delivery system to ensure quality and value for all
14 purchasers and consumers.

15 (j) The Legislature further intends that all existing duties,
16 powers, and authority relating to health care cost, quality, and
17 safety data collection and reporting under current state law continue
18 in full effect.

19 128851. As used in this chapter, the following terms mean:

20 (a) “Administrative claims data” means data that are submitted
21 electronically or otherwise to, or collected by, health insurers,
22 health care service plans, administrators, or other payers of health
23 care services and that are submitted to, or collected for, the
24 purposes of payment to any licensed physician, medical provider
25 group, laboratory, pharmacy, hospital, imaging center, or any other
26 facility or person who is requesting payment for the provision of
27 medical care.

28 (b) “Committee” means the Health Care Cost and Quality
29 Transparency Committee.

30 (c) “Licensed health professional in independent practice” means
31 those licensed health professionals who can order or direct health
32 services or expenditures for patients who are in a category eligible
33 to bill Medi-Cal for services. This includes, but is not limited to,
34 nurse practitioners, physician assistants, dentists, chiropractors,
35 and pharmacists.

36 (d) “Data source” may include any of the following: a licensed
37 physician, other licensed health professional in independent
38 practice, medical provider group, health facility, health care service
39 plan licensed by the Department of Managed Health Care, insurer
40 certificated by the Insurance Commissioner to sell health insurance,

1 any state agency providing or paying for health care or collecting
2 health care data or information, or any other payer for health care
3 services in California.

4 (e) “Encounter data” means data relating to treatment or services
5 rendered by providers to patients and which may be reimbursed
6 on a fee-for-service or capitation basis.

7 (f) “Group” or “medical provider group” means an affiliation
8 of physicians and other health care professionals, whether a
9 partnership, corporation, or other legal form, with the primary
10 purpose of providing medical care.

11 (g) “Health facility” or “health facilities” means health facilities
12 required to be licensed pursuant to Chapter 2 (commencing with
13 Section 1250) of Division 2.

14 (h) “Office” means the Office of Statewide Health Planning and
15 Development.

16 (i) “Risk-adjusted outcomes” means the clinical outcomes of
17 patients grouped by diagnoses or procedures that have been
18 adjusted for demographic and clinical factors.

19 (j) “Secretary” is the Secretary of California Health and Human
20 Services.

21 128852. Any limitations on the addition of data elements
22 pursuant to Chapter 1 (commencing with Section 128675) shall
23 be inapplicable to the extent determined necessary to implement
24 the responsibilities under this chapter. All data collected by the
25 office shall be available to the committee and secretary for the
26 purposes of carrying out their responsibilities under this chapter.
27 The office shall make available to the committee any and all data
28 files, information, and staff resources as may be necessary to assist
29 in and support the responsibilities of the committee.

30

31 Article 2. Health Care Cost and Quality Transparency
32 Committee

33

34 12855. There is hereby created in the California Health and
35 Human Services Agency the California Health Care Cost and
36 Quality Transparency Committee composed of sixteen members.
37 The appointments shall be made as follows:

38 (a) The Governor shall appoint ten members as follows:

39 (1) One researcher with experience in health care data and cost
40 efficiency research.

- 1 (2) One representative of private hospitals.
- 2 (3) One representative of public hospitals.
- 3 (4) One representative of a multi-specialty medical group.
- 4 (5) One representative of health insurers or health care service
- 5 plans.
- 6 (6) One representative of licensed health professionals in
- 7 independent practice.
- 8 (7) One representative of large employers that purchase group
- 9 health care coverage for employees and that is not also a supplier
- 10 or broker of health care coverage.
- 11 (8) One representative of a labor union.
- 12 (9) One representative of employers that purchase group health
- 13 care coverage for their employees or a representative of a nonprofit
- 14 organization that demonstrates experience working with employers
- 15 to enhance value and affordability of health care coverage.
- 16 (10) One representative of pharmacists.
- 17 (b) The Senate Committee on Rules shall appoint three members
- 18 as follows:
- 19 (1) One representative of a labor union.
- 20 (2) One representative of consumers with a demonstrated record
- 21 of advocating health care issues on behalf of consumers.
- 22 (3) One representative of physicians and surgeons who is a
- 23 practicing patient-care physician licensed in the state of California.
- 24 (c) The Assembly Speaker shall appoint three members as
- 25 follows:
- 26 (1) One representative of consumers with a demonstrated record
- 27 of advocating health care issues on behalf of consumers.
- 28 (2) One representative of small employers that purchase group
- 29 health care coverage for employees and that is not also a supplier
- 30 or broker in health care coverage.
- 31 (3) One representative of a nonprofit labor-management
- 32 purchaser coalition that has a demonstrated record of working with
- 33 employers and employee associations to enhance value and
- 34 affordability in health care.
- 35 (d) The following members shall serve in an ex officio,
- 36 nonvoting capacity:
- 37 (1) The Executive Officer of the California Public Employees
- 38 Retirement System or a designee.
- 39 (2) The Director of the Department of Managed Health Care or
- 40 a designee.

1 (3) The Insurance Commissioner or a designee.

2 (4) The Director of the Department of Public Health or a
3 designee.

4 (5) The Director of the State Department of Health Care Services
5 or a designee.

6 (e) The Governor shall designate a member to serve as
7 chairperson for a two-year term. No member may serve more than
8 two, two-year terms as chairperson. All appointments shall be for
9 four-year terms; provided, however, that the initial term shall be
10 two years for members initially filling the positions set forth in
11 paragraphs 1, 2, 4, and 6 of subdivision (a), paragraph 2 of
12 subdivision (b), and paragraph 2 of subdivision (c).

13 128856. The committee shall meet at least once every two
14 months, or more often if necessary to fulfill its duties.

15 128857. The members of the committee shall be reimbursed
16 for any actual and necessary expenses incurred in connection with
17 their duties as members of the committee.

18 128858. The secretary shall provide or contract for
19 administrative support for the committee.

20 128859. The committee shall do all of the following:

21 (a) Develop and recommend to the secretary the Health Care
22 Cost and Quality Transparency Plan, as provided in Article 3
23 (commencing with Section 128865).

24 (b) Monitor the implementation of the Health Care Cost and
25 Quality Transparency Plan.

26 (c) Issue an annual public report, on or before March 1, on the
27 status of implementing this chapter, the resources necessary to
28 fully implement this chapter, and any recommendations for changes
29 to the statutes, regulations, or the transparency plans that would
30 advance the purposes of this chapter.

31 128860. (a) The committee shall appoint at least one technical
32 committee, and may appoint additional technical committees as
33 the committee deems appropriate, and shall include on each such
34 committee academic and professional experts with expertise related
35 to the activities of the committee.

36 (b) (1) The committee shall appoint at least one clinical panel
37 and may appoint additional panels specific to issues that require
38 additional or different clinical expertise. Each clinical panel shall
39 contain a majority of clinicians with expertise related to the
40 activities of the committee and any issue under consideration and

1 shall also include experts in collecting and reporting data. Each
2 clinical panel shall also include two members of the committee,
3 one of whom shall be a representative of hospitals or health
4 professionals and the other of whom shall be a representative of
5 consumers, purchasers or labor unions.

6 (2) For the initial plan, the committee shall appoint at least one
7 clinical panel that shall do all of the following:

8 (i) Issue a written report of recommendations to implement the
9 goals set forth by the committee, including how to measure quality
10 improvement, necessary data elements, and appropriate
11 risk-adjustment methodology. The report shall be submitted to the
12 committee within the time period specified by the committee. The
13 committee shall either adopt the recommendations of the clinical
14 panel or by a two-thirds vote of the committee reject the
15 recommendations. If the committee rejects the recommendations,
16 it shall issue a written finding and rationale for rejecting the
17 recommendations. If the committee rejects the recommendations,
18 it shall refer the issue back to the clinical panel and request
19 additional or modified recommendations in specific areas in which
20 the committee found the recommendations deficient.

21 (ii) Make recommendations to the committee concerning the
22 specific data to be collected and the methods of collection to
23 implement this chapter, assure that the results are statistically valid
24 and accurate, and state any limitations on the conclusions that can
25 be drawn from the data.

26 (iii) Make recommendations concerning the measures necessary
27 to implement the reporting requirements in a manner that is
28 cost-effective and reasonable for data sources and is reliable,
29 timely, and relevant to consumers, purchasers, and health providers.

30 (c) The members of the technical committees and clinical
31 advisory panels shall be reimbursed for any actual and necessary
32 expenses incurred in connection with their duties as members of
33 the technical committee or clinical advisory panel.

34 (d) The committee shall provide opportunities for participation
35 from consumers and patients as well as purchasers and providers
36 at all committee meetings.

37 128861. The committee, technical committee, and clinical
38 panel members, and any contractors, shall be subject to the
39 conflict-of-interest policy of the California Health and Human
40 Services Agency.

1 Article 3. Health Care Cost and Quality Transparency Plan

2
3 128865. (a) (1) The committee shall, within one year after its
4 first meeting, develop and recommend to the secretary an initial
5 Health Care Cost and Quality Transparency Plan.

6 (2) The committee shall periodically review and recommend
7 updates to the Health Care Cost and Quality Transparency Plan.
8 The committee shall conduct a full review every three years, and
9 any recommendations resulting from the review shall be subject
10 to Section 128866.

11 (3) The initial plan and updates to the plan shall result in public
12 reporting of safety, quality and cost efficiency information on the
13 health care system. The purpose of the plan shall be to improve
14 health care cost efficiency, improve health system performance,
15 and promote quality patient outcomes.

16 (4) In developing the initial plan and updates to the plan, the
17 committee shall review existing data gathering and reporting,
18 including existing voluntary efforts.

19 (5) In developing the initial plan and updates to the plan, the
20 committee shall obtain the recommendation of the relevant clinical
21 panel or panels, if any, on the measures to be reported.

22 (b) The plan shall include, but not be limited to, strategies to:

23 (1) Measure, and collect data related to, health care safety and
24 quality, utilization, health outcomes, and cost of health care
25 services from health plans and insurers, medical groups, health
26 facilities, licensed physicians and other licensed health
27 professionals in independent practice.

28 (2) Measure each of the performance domains, including, but
29 not limited to, safety, timeliness, effectiveness, efficiency, quality,
30 equity, and other domains as appropriate.

31 (3) Develop a valid and reliable methodology for collecting and
32 reporting cost and quality information to ensure the integrity of
33 the data and reflect the intensity, cost, and scope of services
34 provided and that the data is collected from the most appropriate
35 data source.

36 (4) Measure and collect data related to disparities in health
37 outcomes among various populations and communities, including
38 racial and ethnic groups.

39 (5) Use and build on existing data collection standards, methods,
40 and definitions to the greatest extent possible to accomplish the

- 1 goals of this chapter in an efficient and effective manner, including
 2 those data collected by the state and federal governments.
- 3 (6) Incorporate and utilize administrative claims data to the
 4 extent that it is the most efficient method of collecting valid and
 5 reliable data.
- 6 (7) Improve coordination, alignment, and timeliness of data
 7 collection, state and federal reporting practices and standards, and
 8 existing mandatory and voluntary measurement and reporting
 9 activities by existing public and private entities, taking into account
 10 the reporting burden on providers.
- 11 (8) Provide public reports, analyses, and data on the health care
 12 quality, safety, and performance measures of health plans and
 13 insurers, medical groups, health facilities, licensed physicians, and
 14 other licensed health professionals in independent practice, that
 15 are accurate, statistically valid, and descriptive of how the data
 16 were derived.
- 17 (9) Maintain patient confidentiality consistent with state and
 18 federal medical and patient privacy laws.
- 19 (10) Coordinate and streamline existing related data collection
 20 and reporting activities within state government.
- 21 (11) Participate in the monitoring of implementation of the plan,
 22 including a timeline and prioritization of the planned data
 23 collection, analyses and reports.
- 24 (12) Participate in the monitoring of data collection, continuous
 25 quality improvement, and reporting functions.
- 26 (13) Assess compliance with data collection requirements
 27 needed to implement this chapter.
- 28 (14) Recommend a fee schedule sufficient to fund the
 29 implementation of this chapter.
- 30 (c) The secretary may contract with a qualified public or private
 31 agency or academic institution to assist in the review of existing
 32 data collection programs or to conduct other research or analysis
 33 deemed necessary for the committee or secretary to complete and
 34 implement the Health Care Cost and Quality Transparency Plan
 35 or to meet the obligations of this chapter.
- 36 128866. (a) Within 60 days of receipt of the Health Care Cost
 37 and Quality Transparency Plan recommended by the committee,
 38 the secretary shall do one of the following:
- 39 (1) Advise the committee that the recommended plan is accepted
 40 and implementing regulations shall be drafted and submitted to

1 the Office of Administrative Law pursuant to the Administrative
2 Procedures Act, Chapter 3.5 (commencing with Section 11340)
3 of Part 1 of Division 3 of Title 2 of the Government Code.

4 (2) Refer the plan back to the committee and request additional
5 or modified recommendations in specific areas in which the
6 secretary finds the plan is deficient. If referred back to the
7 committee, the secretary shall respond to any modified
8 recommendation in the manner provided in this section.

9 (b) Every six years after implementation, commencing with
10 2014, the secretary shall report to the Legislature on the work of
11 the committee and whether the committee should be continued in
12 the manner described in this article or whether changes should be
13 made to the law.

14
15 Article 4. Implementation of Health Care Cost and Quality
16 Transparency Plan
17

18 128867. (a) After acceptance of the plan pursuant to Section
19 128866, the secretary shall be responsible for timely
20 implementation of the approved plan. The secretary shall assure
21 timely implementation by the office, which shall include, but not
22 be limited to, the following:

23 (1) Provide data, information, and reports as may be required
24 by the committee to assist in its responsibilities under this chapter

25 (2) Determine the specific data to be collected and the methods
26 of collection to implement this chapter, consistent with the
27 approved plan, and assure that the results are statistically valid and
28 accurate as well as risk-adjusted where appropriate.

29 (3) Determine the measures necessary to implement the reporting
30 requirements in a manner that is cost-effective and reasonable for
31 data sources and is reliable, timely, and relevant for consumers,
32 purchasers, and providers.

33 (4) Collect the data consistent with the data reporting
34 requirements of the approved plan including, but not limited to,
35 data on quality, health outcomes, cost, and utilization.

36 (5) Audit, as necessary, the accuracy of any and all data
37 submitted pursuant to this chapter.

38 (6) Seek to establish agreements for voluntary reporting of health
39 care claims and data from any and all health care data sources that
40 are not subject to mandatory reporting pursuant to this chapter in

1 order to assure the most comprehensive systemwide data on health
2 care costs and quality.

3 (7) Fully protect patient privacy and confidentiality, in
4 compliance with state and federal privacy laws, while preserving
5 the ability to analyze the data. Any individual patient information
6 obtained pursuant to this chapter shall be exempt from the
7 disclosure requirements of the Public Records Act (Chapter 3.5
8 (commencing with Section 6250) of Division 7 of Title 1 of the
9 Government Code.

10 (9) Adopt the same procedures for health care providers as those
11 specified in Section 128750 and adopt substantially similar
12 procedures for other data sources to ensure that all data sources
13 identified in any outcome report have a reasonable opportunity to
14 review, comment on, and appeal any outcome report in which the
15 data source is identified before it is released to the public.

16 (b) The secretary and office shall consult with the committee
17 in implementing this chapter, and shall cooperate with the
18 committee in fulfilling the committee’s responsibility to monitor
19 implementation activities.

20 (c) All state agencies shall cooperate with the secretary and the
21 office to implement the Health Care Cost and Quality Transparency
22 Plan approved by the secretary.

23 (d) The secretary or the office shall adopt regulations necessary
24 to carry out the intent of this chapter.

25 128868. Nothing in this chapter shall be construed to authorize
26 the disclosure of any confidential information concerning
27 contracted rates between health care providers and payers or any
28 other data source, but nothing in this section shall prevent the
29 disclosure of information on the relative or comparative cost to
30 payers or purchasers of health care services, consistent with the
31 requirements of this chapter.

32 128869. (a) Patient social security numbers and any other data
33 elements that the office believes could be used to determine the
34 identity of an individual patient shall be exempt from the disclosure
35 requirements of the California Public Records Act (Chapter 3.5
36 (commencing with Section 6250) of Division 7 of Title 1 of the
37 Government Code).

38 (b) No person reporting data pursuant to this section shall be
39 liable for damages in any action based on the use or misuse of
40 patient-identifiable data that has been mailed or otherwise

1 transmitted to the office pursuant to the requirements of this
2 chapter.

3 (c) No communication of data or information by a data source
4 to the committee, the secretary or the office shall constitute a
5 waiver of privileges preserved by Sections 1156, 1156.1, or 1157
6 of the Evidence Code or of Section 1370 of the Health and Safety
7 Code.

8 (d) Information, documents or records from original sources
9 otherwise subject to discovery or introduction into evidence shall
10 not be immune from discovery or introduction into evidence merely
11 because they were also provided to the committee or office
12 pursuant to this chapter.

13 128870. The office shall solicit input from interested
14 stakeholders and convene meetings to receive input on the creation
15 of a fee schedule to implement the provisions of this section. This
16 stakeholder process shall occur in a manner that allows for
17 meaningful review of the information and fiscal projections by the
18 interested stakeholders. After the stakeholder process has been
19 convened and used in the development of a proposal, the office
20 shall provide the secretary with a proposal that will, to the extent
21 possible, identify a fee schedule and other financial resources for
22 the implementation of this chapter and allow for the recovery of
23 costs of implementing centralized data collection, and effective
24 analysis and reporting activities under this chapter.

25 (b) The schedule of fees, including specific fees charged to each
26 data source and user, shall be approved by the Legislature and
27 Governor in the annual Budget Act. The annual budget of the
28 committee shall be presented and justified to the Legislature with
29 an annual work plan including a description of the data sources,
30 data, elements, use of the data and the number and frequency of
31 reports to be made available.

32 (c) The total amount of fees charged by the office to a hospital
33 to recover the costs of implementing this chapter, and the fees
34 charged to that hospital pursuant to Section 127280 of the Health
35 and Safety Code shall not exceed 0.06 percent of the gross
36 operating cost of the hospital for the provision of health care
37 services for its last fiscal year that ended on or before June 30 of
38 the preceding calendar year.

39 128871. There is hereby established in the State Treasury the
40 Health Care Cost and Quality Transparency Fund to support the

1 implementation of this chapter. All fees and contributions collected
2 by the office pursuant to Section 128870 shall be deposited in this
3 fund and used to support the implementation of this chapter.
4 Expenditures shall be subject to appropriation in the annual Budget
5 Act.

6 SEC. 34. Section 130545 is added to the Health and Safety
7 Code, to read:

8 130545. (a) The State Department of Health Care Services
9 shall identify best practices related to e-prescribing modalities and
10 standards and shall make recommendations for statewide adoption
11 of e-prescribing on or before January 1, 2009.

12 (b) The State Department of Health Care Services shall develop
13 a pilot program to foster the adoption and use of electronic
14 prescribing by health care providers that contract with Medi-Cal.
15 The implementation of this Medi-Cal pilot is contingent upon the
16 availability of FFP or federal grant funds. The department may
17 provide electronic prescribing technology, including equipment
18 and software, to participating Medi-Cal prescribers.

19 SEC. 34.3. Section 796.02 of the Insurance Code is amended
20 to read:

21 796.02. (a) Compensation of a person retained by a disability
22 insurer to review claims for health care services shall not be based
23 on either of the following:

24 (1) A percentage of the amount by which a claim is reduced for
25 payment.

26 (2) The number of claims or the cost of services for which the
27 person has denied authorization or payment.

28 (b) This section shall become inoperative on December 1, 2008,
29 and, as of January 1, 2009, is repealed, unless a later enacted
30 statute, that becomes operative on or before January 1, 2009,
31 deletes or extends the dates on which it becomes inoperative and
32 is repealed.

33 SEC. 34.5. Section 796.02 is added to the Insurance Code, to
34 read:

35 796.02. (a) Compensation of a person employed by or
36 contracted with a disability insurer to review claims or eligibility
37 for health care services shall not be based on either of the
38 following:

39 (1) A percentage of the amount by which a claim is reduced for
40 payment.

1 (2) The number of claims or the cost of services for which the
2 person has denied authorization or payment.

3 (b) This section shall become operative on December 1, 2008.

4 SEC. 34.7. Section 796.05 is added to the Insurance Code, to
5 read:

6 796.05. (a) No disability insurer shall set performance goals
7 or quotas or provide additional compensation to any person
8 employed by or contracted with the disability insurer based on the
9 number of persons for which coverage is rescinded or the financial
10 savings to the disability insurer associated with the rescission of
11 coverage.

12 (b) This section shall become operative on December 1, 2008.

13 SEC. 35. Section 10113.10 is added to the Insurance Code, to
14 read:

15 10113.10. (a) Notwithstanding Section 10270.95 and except
16 as provided in subdivision (f), a health insurer selling health
17 insurance shall, on and after July 1, 2010, expend in the form of
18 health care benefits no less than 85 percent of the aggregate dues,
19 fees, premiums, or other periodic payments received by the insurer.
20 For purposes of this section, the insurer may deduct from the
21 aggregate dues, fees, premiums, or other periodic payments
22 received by the insurer the amount of income taxes or other taxes
23 that the insurer expensed. For purposes of this section, "health care
24 benefits" shall mean health care services that are either provided
25 or reimbursed by the insurer or its contracted providers as benefits
26 to its policyholders and insurers.

27 (b) (1) In addition to the health care benefits defined in
28 subdivision (a), health care benefits shall include:

29 (A) The costs of programs or activities, including training and
30 the provision of informational materials that are determined as
31 part of the regulation under subdivision (d) to improve the
32 provision of quality care, improve health care outcomes, or
33 encourage the use of evidence-based medicine.

34 (B) Disease management expenses using cost-effective
35 evidence-based guidelines.

36 (C) Plan medical advice by telephone.

37 (D) Payments to providers as risk pool payments of
38 pay-for-performance initiatives.

1 (2) Health care benefits shall not include administrative costs
2 listed in Section 1300.78 of Title 28 of the California Code of
3 Regulations in effect on January 1, 2007.

4 (c) To assess compliance with this section, an insurer with a
5 valid certificate of authority may average its total costs across all
6 health insurance policies issued, amended, or renewed in
7 California, and all health care service plan contracts issued,
8 amended, or renewed by its affiliated health care service plans
9 which are licensed to operate in California, except for those
10 contracts listed in subdivision (f) of Section 1378.1 of the Health
11 and Safety Code.

12 (d) The department and the Department of Managed Health
13 Care shall jointly adopt and amend regulations to implement this
14 section and Section 1378.1 of the Health and Safety Code to
15 establish uniform reporting by health care service plans and
16 insurers of the information necessary to determine compliance
17 with this section. These regulations may include additional
18 elements in the definition of health care benefits not identified in
19 paragraph (1) of subdivision (b) in order to consistently
20 operationalize the requirements of this section among health
21 insurers and health plans, but such regulatory additions shall be
22 consistent with the legislative intent that health insurers expend at
23 least 85 percent of aggregate payments as provided in subdivision
24 (a) on health care benefits.

25 (e) The department may exclude from the determination of
26 compliance with the requirement of subdivision (a) any new health
27 insurance policies for up to the first two years that these policies
28 are offered for sale in California, provided that the commissioner
29 determines that the new policies are substantially different from
30 the existing policies being issued, amended, or renewed by the
31 insurer seeking the exclusion.

32 (f) This section shall not apply to Medicare supplement policies,
33 short-term limited duration health insurance policies, vision-only,
34 dental-only, behavioral health-only, pharmacy-only policies,
35 CHAMPUS-supplement or TRICARE-supplement insurance
36 policies, or to hospital indemnity, hospital-only, accident-only, or
37 specified disease insurance policies that do not pay benefits on a
38 fixed benefit, cash payment only basis.

39 SEC. 36. Section 10113.11 is added to the Insurance Code, to
40 read:

1 10113.11. (a) A health insurer may provide notice by electronic
2 transmission and shall be deemed to have fully complied with the
3 specific statutory or regulatory requirements to provide notice by
4 United States mail to an applicant or insured if it complies with
5 all of the following requirements:

6 (1) Obtains authorization from the applicant or insured to
7 provide notices by electronic transmission and to cease providing
8 notices by United States mail. "Authorization" means the
9 agreement by the applicant, enrollee, or subscriber through
10 interactive voice response, the Internet or other similar medium,
11 or in writing, to receive notices by electronic transmission.

12 (2) Uses an authorization process, approved by the department,
13 in which the applicant or insured confirms understanding of and
14 agreement with the specific notices or materials that will be
15 provided by electronic transmission.

16 (3) Complies with the specific statutory or regulatory
17 requirements as to the content of the notices it sends by electronic
18 transmission.

19 (4) Provides for the privacy of the notice as required by state
20 and federal laws and regulations.

21 (5) Allows the applicant or insured at any time to terminate the
22 authorization to provide notices by electronic transmission and
23 receive the notices through the United States mail, if specific
24 statutory or regulatory requirements require notice by mail.

25 (6) Sends the electronic transmission of a notice to the last
26 known electronic address of the applicant or insured. If the
27 electronic transmission of the notice fails to reach its intended
28 recipient twice, the health insurer shall resume sending all notices
29 to the last known United States mail address of the applicant or
30 insured.

31 (7) Maintains an Internet Web site where the applicant or insured
32 may access the notices sent by electronic transmission.

33 (8) Informs the applicant, enrollee, or subscriber how to
34 terminate the authorization to provide notices sent by electronic
35 transmission.

36 (b) A health insurer shall not use the electronic mail address of
37 an applicant or insured that it obtained for the purposes of
38 providing notice pursuant to subdivision (a) for any purpose other
39 than communicating with the enrollee, applicant, or subscriber
40 about his or her policy, plan, or benefits.

1 (c) No person other than the applicant or insured to whom the
2 medical information in the notice pertains or a representative
3 lawfully authorized to act on behalf of the applicant or insured,
4 may authorize the transmission of medical information by
5 electronic transmission. “Medical information” for these purposes
6 shall have the meaning set forth in subdivision (g) of Section 56.05
7 of the Civil Code. The transmission of any medical information,
8 as that term is used in subdivision (g) of Section 56.05 of the Civil
9 Code, shall comply with the Confidentiality of Medical Information
10 Act (Part 2.6 (commencing with Section 56) of Division 1 of the
11 Civil Code).

12 (d) A notice transmitted electronically pursuant to this section
13 is a private and confidential communication, and it shall be
14 unlawful for a person, other than the applicant or insured to whom
15 the notice is addressed, to read or otherwise gain access to the
16 notice without the express, specific permission of the notice’s
17 addressee. This subdivision shall not apply to a health care
18 provider, health insurer, or contractor of a health care provider or
19 health insurer of an applicant or insured if the health care provider,
20 health care insurer, or contractor of a health care provider or health
21 insurer is authorized to have access to the medical information
22 pursuant to the Confidentiality of Medical Information Act (Part
23 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

24 (e) A health insurer may not impose additional fees or a
25 differential if an applicant or insured elects not to receive notices
26 by electronic transmissions.

27 (f) Notices that may be made by electronic transmission include
28 explanation of benefits; distribution of the insurer’s policies and
29 certificates of coverage; a list of contracting providers; responses
30 to inquiries from insureds; changes in rates pursuant to Sections
31 10113.7 and 10901.3; and notices related to underwriting decisions
32 pursuant to Section 791.10. A health insurer may not transmit
33 through electronic means any notice that may affect the eligibility
34 for, or continued enrollment in, coverage.

35 SEC. 37. Section 10123.56 is added to the Insurance Code, to
36 read:

37 10123.56. (a) On and after January 1, 2009, every policy of
38 health insurance, except for a Medicare supplement policy, that
39 covers hospital, medical, or surgical expenses on a group basis
40 shall offer to include a Healthy Action Incentives and Rewards

1 Program, as described in subdivision (b), to be implemented in
2 connection with a health insurance policy, under such terms and
3 conditions as may be agreed upon between the group policyholder
4 and the health insurer. Every insurer shall communicate the
5 availability of that program to all prospective group policyholders
6 with whom it is negotiating and to existing group policyholders
7 upon renewal.

8 (b) For purposes of this section, benefits under a Healthy Action
9 Incentives and Rewards Program shall provide for all of the
10 following where appropriate:

11 (1) Health risk appraisals to be used to assess an individual's
12 overall health status and to identify risk factors, including, but not
13 limited to, smoking and smokeless tobacco use, alcohol abuse,
14 drug use, and nutrition and physical activity practices.

15 (2) Enrollee access to an appropriate health care provider, as
16 medically necessary, to review and address the results of the health
17 risk appraisal. In addition, where appropriate, the Healthy Action
18 Incentives and Rewards Program may include follow-up through
19 a Web-based tool or a nurse hotline either in combination with a
20 referral to a provider or separately.

21 (3) Incentives or rewards for policyholders to become more
22 engaged in their health care and to make appropriate choices that
23 support good health, including obtaining health risk appraisals,
24 screening services, immunizations, or participating in healthy
25 lifestyle programs and practices. These programs and practices
26 may include, but need not be limited to, smoking cessation,
27 physical activity, or nutrition. Incentives may include, but need
28 not be limited to, health premium reductions, differential
29 copayment or coinsurance amounts, and cash payments. Rewards
30 may include, but need not be limited to, nonprescription pharmacy
31 products or services not otherwise covered under a policyholder's
32 health insurance policy, exercise classes, gym memberships, and
33 weight management programs. If an insurer elects to offer an
34 incentive in the form of a reduction in the premium amount, the
35 premium reduction shall be standardized and uniform for all groups
36 and policyholders and shall be offered only after the successful
37 completion of the specified program or practice by the insured or
38 policyholder.

39 (c) (1) An insurer subject to this section shall offer and price
40 all Healthy Action Incentives and Rewards Programs approved by

1 the commissioner consistently across all groups, potential groups,
2 and individuals and offer and price the programs without regard
3 to the health status, prior claims experience, or risk profile of the
4 members of a group. An insurer shall not condition the offer,
5 delivery, or renewal of a policy that covers hospital, medical or
6 surgical expenses on the group's purchase, acceptance or
7 enrollment in a Healthy Action Incentives and Rewards Program.
8 Rewards and incentives established in the program may not be
9 designed, provided, or withheld based on the actual health service
10 utilization or health care claims experience of the group, members
11 of the group, or the individual.

12 (2) In order to demonstrate compliance with this section, a health
13 insurer shall file the program description and design with the
14 commissioner. The commissioner shall disapprove, suspend, or
15 withdraw any product or program developed pursuant to this
16 section if the commissioner determines that the product or product
17 design has the effect of allowing insurers to market, sell, or price
18 health coverage for healthier lower risk profile groups in a
19 preferential manner that is inconsistent with the requirement to
20 offer, market and sell products pursuant to Chapter 8 (commencing
21 with Section 10700) and Chapter 9.6 (commencing with Section
22 10919).

23 (d) This section shall supplement, and not supplant, any other
24 section in this chapter concerning requirements for insurers to
25 provide health care services, childhood immunizations, adult
26 immunizations, and preventive care services.

27 (e) This section shall only be implemented if and to the extent
28 allowed under federal law. If any portion of this section is held to
29 be invalid, as determined by a final judgment of a court of
30 competent jurisdiction, this section shall become inoperative.

31 SEC. 38. Section 10176.15 is added to the Insurance Code, to
32 read:

33 10176.15. For purposes of subdivision (d) of Section 10176.10,
34 "comparable benefits" means any health insurance policy in the
35 same coverage choice category, as determined by the department
36 and the Department of Managed Health Care pursuant to Section
37 10930, that a closed block of business would have been in had that
38 block of business not been closed. If the coverage benefits provided
39 in the closed block of business do not meet or exceed the minimum

1 health care coverage requirements of Section 10923, they shall be
2 deemed comparable to the lowest coverage choice category.

3 SEC. 39. Section 10273.6 of the Insurance Code is amended
4 to read:

5 10273.6. All individual health benefit plans, except for
6 short-term limited duration insurance, shall be renewable with
7 respect to all eligible individuals or dependents at the option of
8 the individual except as follows:

9 (a) For nonpayment of the required premiums or contributions
10 by the individual in accordance with the terms of the health
11 insurance coverage or the timeliness of the payments.

12 (b) For fraud or intentional misrepresentation of material fact
13 under the terms of the coverage by the individual.

14 (c) Movement of the individual contractholder outside the
15 service area but only if coverage is terminated uniformly without
16 regard to any health status-related factor of covered individuals.

17 (d) If the disability insurer ceases to provide or arrange for the
18 provision of health care services for new individual health benefit
19 plans in this state; provided, however, that the following conditions
20 are satisfied:

21 (1) Notice of the decision to cease new or existing individual
22 health benefit plans in this state is provided to the commissioner
23 and to the individual policy or contractholder at least 180 days
24 prior to discontinuation of that coverage.

25 (2) Individual health benefit plans shall not be canceled for 180
26 days after the date of the notice required under paragraph (1) and
27 for that business of a disability insurer that remains in force, any
28 disability insurer that ceases to offer for sale new individual health
29 benefit plans shall continue to be governed by this section with
30 respect to business conducted under this section.

31 (3) A disability insurer that ceases to write new individual health
32 benefit plans in this state after the effective date of this section
33 shall be prohibited from offering for sale individual health benefit
34 plans in this state for a period of five years from the date of notice
35 to the commissioner.

36 (e) If the disability insurer withdraws an individual health benefit
37 plan from the market; provided, that the disability insurer notifies
38 all affected individuals and the commissioner at least 90 days prior
39 to the discontinuation of these plans, and that the disability insurer
40 makes available to the individual all health benefit plans that it

1 makes available to new individual businesses without regard to a
2 health status-related factor of enrolled individuals or individuals
3 who may become eligible for the coverage.

4 This section shall become inoperative on the date that Section
5 10937 becomes operative.

6 SEC. 42. Chapter 9.6 (commencing with Section 10919) is
7 added to Part 2 of Division 2 of the Insurance Code, to read:

8
9 CHAPTER 9.6. INDIVIDUAL MARKET REFORM AND GUARANTEE
10 ISSUE
11

12 10919. It is the intent of the Legislature to do both of the
13 following:

14 (a) Guarantee the availability and renewability of health
15 coverage through the private health insurance market to individuals.

16 (b) Require that health care service plans and health insurers
17 issuing coverage in the individual market compete on the basis of
18 price, quality, and service, and not on risk selection.

19 10920. For purposes of this chapter, the following terms shall
20 have the following meanings:

21 (a) “Anniversary date” means the calendar date one year from,
22 and each subsequent year thereafter, the date an individual enrolls
23 in a health insurance policy.

24 (b) “Coverage choice category” means the category of health
25 insurance policies and health plan contracts established by the
26 department and the Department of Managed Health Care pursuant
27 to Section 10930.

28 (c) “Dependent” means the spouse, registered domestic partner,
29 or child of an individual, subject to applicable terms of the health
30 insurance policy covering the individual.

31 (d) “Health insurance policy” means an individual disability
32 insurance policy offered, sold, amended, or renewed to individuals
33 and their dependents that provides coverage for hospital, medical,
34 or surgical benefits. The term shall not include any of the following
35 kinds of insurance:

36 (1) Accidental death and accidental death and dismemberment.

37 (2) Disability insurance, including hospital indemnity,
38 accident-only, and specified disease insurance that pays benefits
39 on a fixed benefit, cash-payment-only basis.

40 (3) Credit disability, as defined in Section 779.2.

- 1 (4) Coverage issued as a supplement to liability insurance.
- 2 (5) Disability income, as defined in subdivision (i) of Section
- 3 799.01.
- 4 (6) Insurance under which benefits are payable with or without
- 5 regard to fault and that is statutorily required to be contained in
- 6 any liability insurance policy or equivalent self-insurance.
- 7 (7) Insurance arising out of a workers' compensation or similar
- 8 law.
- 9 (8) Long-term care coverage.
- 10 (9) Dental coverage.
- 11 (10) Vision coverage.
- 12 (11) Medicare supplement, CHAMPUS-supplement or
- 13 Tricare-supplement, behavioral health-only, pharmacy-only,
- 14 hospital indemnity, hospital-only, accident-only, or specified
- 15 disease insurance that does not pay benefits on a fixed benefit,
- 16 cash-payment-only basis.
- 17 (e) "Health insurer" means a disability insurer that offers and
- 18 sells health insurance.
- 19 (f) "Health plan" means a health care service plan, as defined
- 20 in subdivision (f) of Section 1345 of the Health and Safety Code,
- 21 that is lawfully engaged in providing, arranging, paying for, or
- 22 reimbursing the cost of health care services and is offering or
- 23 selling health care service plan contracts in the individual market.
- 24 A health plan shall not include a specialized health care service
- 25 plan.
- 26 (g) "Health plan contract" means an individual health care
- 27 service plan contract offered, sold, amended, or renewed to
- 28 individuals and their dependents and shall not include long-term
- 29 care insurance, dental, or vision coverage. In addition, the term
- 30 shall not include a specialized health care service plan contract,
- 31 as defined in subdivision (o) of Section 1345 of the Health and
- 32 Safety Code.
- 33 (h) "Purchasing pool" means the program established under
- 34 Part 6.45 (commencing with Section 12699.201).
- 35 (i) "Rating period" means the period for which premium rates
- 36 established by an insurer are in effect and shall be no less than 12
- 37 months beginning on the effective date of the subscriber's health
- 38 insurance policy.
- 39 (j) "Risk adjustment factor" means the percentage adjustment
- 40 to be applied to the standard risk rate for a particular individual,

1 based upon any expected deviations from standard claims due to
 2 the health status of the individual.

3 (k) “Risk category” means the following characteristics of an
 4 individual: age, geographic region, and family composition of the
 5 individual, plus the health insurance policy selected by the
 6 individual.

7 (1) No more than the following age categories may be used in
 8 determining premium rates:

9 Under 1.

10 1–18.

11 19–24.

12 25–29.

13 30–34.

14 35–39.

15 40–44.

16 45–49.

17 50–54.

18 55–59.

19 60–64.

20 65 and over.

21 However, for the 65 and over age category, separate premium
 22 rates may be specified depending upon whether coverage under
 23 the health insurance policy will be primary or secondary to benefits
 24 provided by the federal Medicare Program pursuant to Title XVIII
 25 of the federal Social Security Act.

26 (2) Health insurers shall determine rates using no more than the
 27 following family size categories:

28 (A) Single.

29 (B) More than one child 18 years of age or under and no adults.

30 (C) Married couple or registered domestic partners.

31 (D) One adult and child.

32 (E) One adult and children.

33 (F) Married couple and child or children, or registered domestic
 34 partners and child or children.

35 (3) (A) In determining rates for individuals, a health insurer
 36 that operates statewide shall use no more than nine geographic
 37 regions in the state, have no region smaller than an area in which
 38 the first three digits of all its ZIP Codes are in common within a
 39 county, and divide no county into more than two regions. Health
 40 insurers shall be deemed to be operating statewide if their coverage

1 area includes 90 percent or more of the state's population.
2 Geographic regions established pursuant to this section shall, as a
3 group, cover the entire state, and the area encompassed in a
4 geographic region shall be separate and distinct from areas
5 encompassed in other geographic regions. Geographic regions
6 may be noncontiguous.

7 (B) (i) In determining rates for individuals, a health insurer that
8 does not operate statewide shall use no more than the number of
9 geographic regions in the state that is determined by the following
10 formula: the population, as determined in the last federal census,
11 of all counties that are included in their entirety in a health insurer's
12 service area divided by the total population of the state, as
13 determined in the last federal census, multiplied by nine. The
14 resulting number shall be rounded to the nearest whole integer.
15 No region may be smaller than an area in which the first three
16 digits of all its ZIP Codes are in common within a county and no
17 county may be divided into more than two regions. The area
18 encompassed in a geographic region shall be separate and distinct
19 from areas encompassed in other geographic regions. Geographic
20 regions may be noncontiguous. No health insurer shall have less
21 than one geographic area.

22 (ii) If the formula in clause (i) results in a health insurer that
23 operates in more than one county having only one geographic
24 region, then the formula in clause (i) shall not apply and the health
25 insurer may have two geographic regions, provided that no county
26 is divided into more than one region.

27 Nothing in this section shall be construed to require a health
28 insurer to establish a new service area or to offer health insurance
29 on a statewide basis, outside of the health insurer's existing service
30 area.

31 (4) A health insurer may rate its entire portfolio of health
32 insurance policies in accordance with expected costs or other
33 market considerations, but the rate for each health insurance policy
34 shall be set in relation to the balance of the portfolio, as certified
35 by an actuary.

36 (5) Each health insurance policy shall be priced as determined
37 by each health insurer to reflect the difference in benefit variation,
38 or the effectiveness of a provider network, and each insurer may
39 adjust the rate for a specific policy for risk selection only to the
40 extent permitted by subdivision (d) of Section 10937.

1 (l) “Standard risk rate” means the rate applicable to an individual
2 in a particular risk category.

3 (m) “Subscriber” means the individual who is enrolled in a
4 health insurance policy, is the basis for eligibility for enrollment
5 in the policy, and is responsible for payment to the health insurer.

6 10922. On and after March 31, 2009, a health insurer shall not
7 offer to an individual a health insurance policy that provides less
8 than minimum creditable coverage, as defined by the Managed
9 Risk Medical Insurance Board pursuant to Section 12739.50.

10 10925. (a) Notwithstanding Chapter 15 (commencing with
11 Section 8899.50) of Division 1 of Title 2 of the Government Code
12 and Section 10922, a health insurer may renew an individual health
13 insurance policy for anyone enrolled on March 1, 2009, indefinitely
14 without increasing benefits to meet the required minimum
15 creditable coverage established by the Managed Risk Medical
16 Insurance Board pursuant to Section 12739.50. Those individual
17 health insurance policies, however, may not be offered to new
18 enrollment, unless they are amended to meet the minimum
19 creditable coverage established by the Managed Risk Medical
20 Insurance Board pursuant to Section 12739.50. In offering those
21 policies for renewal, rates determined by health insurers shall meet
22 the requirements of Sections 10920 and 10937. An individual who
23 maintains coverage in a health insurance policy pursuant to this
24 section shall be deemed to be in compliance with Section 8899.50
25 of the Government Code.

26 (b) A health insurer shall not cease to renew coverage in an
27 individual health insurance policy described in subdivision (a)
28 except as permitted pursuant to Section 10176.10.

29 (c) On and after March 1, 2009, the director shall not approve
30 for offer and sale in this state any new individual health insurance
31 policy that does not meet or exceed the minimum creditable
32 coverage requirements established by the Managed Risk Medical
33 Insurance Board pursuant to Section 12739.50.

34 (d) Effective July 1, 2010, all individual health insurance
35 policies approved, offered, and sold prior to March 1, 2009, that
36 do not comply with minimum creditable coverage standards
37 adopted by the Managed Risk Medical Insurance Board pursuant
38 to Section 12739.50, exclusively because the policy includes a
39 lifetime benefit maximum inconsistent with the standard minimum

1 creditable coverage shall be modified to comply with the standards
2 for minimum creditable coverage.

3 (e) This section shall become operative on January 1, 2009.

4 10926. A health insurer shall, in addition to complying with
5 the applicable provisions of this code and the applicable rules of
6 the commissioner, comply with this chapter.

7 10927. This chapter shall not apply to health insurance policies
8 for coverage of Medicare services pursuant to contracts with the
9 United States government, Medicare supplement, Medi-Cal
10 contracts with the State Department of Health Care Services,
11 Healthy Families Program contracts with the Managed Risk
12 Medical Insurance Board, long-term care coverage, specialized
13 health care service plan contracts, as defined in subdivision (o) of
14 Section 1345 of the Health and Safety Code, or the purchasing
15 pool established under Part 6.45 (commencing with Section
16 12699.201).

17 10928. (a) Except for the health insurance policies described
18 in subdivision (a) of Section 10925, a health insurer shall fairly
19 and affirmatively offer, market, and sell all of the insurer's policies
20 that are sold to individuals to all individuals in each service area
21 in which the health insurer provides or arranges for the provision
22 of health care services.

23 (b) A health insurer may not reject an application from an
24 individual, or his or her dependents, for an individual health
25 insurance policy, or refuse to renew an individual health insurance
26 policy, if all of the following requirements are met:

27 (1) The individual agrees to make the required premium
28 payments.

29 (2) The individual and his or her dependents who are to be
30 covered by the health insurance policy work or reside in the service
31 area in which the health insurer provides or otherwise arranges for
32 the provision of health care services.

33 (3) The individual provides the information requested on the
34 application to determine the appropriate rate.

35 (c) Notwithstanding subdivision (b), if an individual, or his or
36 her dependents, applies for a health insurance policy in a coverage
37 choice category for which he or she is not eligible pursuant to
38 Section 10934, the health insurer may reject that application
39 provided that the insurer also offers the individual and his or her
40 dependents coverage in the appropriate coverage choice category.

1 (d) Notwithstanding subdivision (b), a health insurer is not
2 required to renew an individual health insurance policy if any of
3 the conditions listed in subdivision (a) of Section 10936 are met.

4 (e) Notwithstanding any other provision of this chapter or of a
5 health insurance policy, every health insurer shall comply with the
6 requirements of Chapter 7 (commencing with Section 3750) of
7 Part 1 of Division 9 of the Family Code and Section 14124.94 of
8 the Welfare and Institutions Code.

9 (f) A health insurer may require an individual to provide
10 information on his or her health status or health history, or that of
11 his or her dependents, in the application for enrollment to the extent
12 required to apply the risk adjustment factor permitted pursuant to
13 subdivision (d) of Section 10937. The health insurer shall use the
14 standardized form and uniform evaluation process developed for
15 this purpose by the Director of the Department of Managed Health
16 Care pursuant to Section 1399.840 of the Health and Safety Code.
17 After the individual health insurance policy’s effective date of
18 coverage, a health insurer may request that the enrollee provide
19 information voluntarily on his or her health history or health status,
20 or that of his or her dependents, for purposes of providing care
21 management services, including disease management services.

22 (g) Notwithstanding subdivision (b), a health insurer may reject
23 an application for any person who has been a resident of California
24 for six months or less unless one of the following applies: (1) the
25 person is a federally eligible defined individual pursuant to Section
26 10785 or Section 1399.801 of the Health and Safety Code; or (2)
27 the person can demonstrate a minimum of two years of prior
28 creditable coverage at least equivalent to the minimum creditable
29 coverage developed by the Managed Risk Medical Insurance Board
30 pursuant to Section 12739.50 and providing the person applies for
31 coverage in California within 62 days of termination or cancellation
32 of the prior creditable coverage.

33 (h) Notwithstanding subdivision (b), a health plan may reject
34 an application for coverage from either of the following:

35 (1) A person who is exempt from the requirements of Section
36 8899.50 of the Government Code because the person or family
37 has an income at or below 250 percent of the federal poverty level
38 and the person’s or family’s share of premium for minimum
39 creditable coverage exceeds 5 percent of his or her family income,

1 except for those individuals meeting the criteria in paragraph (1)
2 or (2) of subdivision (g).

3 (2) A person exempted from the requirements of Section 8899.50
4 of the Government Code pursuant to any exemption authorized or
5 granted by the Managed Risk Medical Insurance Board pursuant
6 to Section 12739.501, for the time period of the exemption, as
7 determined by the board.

8 (i) Notwithstanding Section 10944, this section shall not become
9 operative until the authority under Section 12739.51 is
10 implemented.

11 10929. (a) A health insurer shall not impose any preexisting
12 condition exclusions, waived conditions, or postenrollment
13 waiting or affiliation periods on any health insurance policy issued,
14 amended, or renewed pursuant to this chapter, except as provided
15 under subdivision (b) of this section.

16 (b) After the requirement to guarantee issue of coverage under
17 Section 10928 has been in effect for nine months, a health insurer
18 may impose a preexisting condition exclusion of up to 12 months
19 for any person who fails to comply for more than 62 days with the
20 requirement to maintain coverage under Section 8899.50 of the
21 Government Code, providing, however, that the exclusion may
22 not exceed the length of time that the person failed to comply with
23 the requirements of that section. "Preexisting condition exclusion"
24 means a contract provision that excludes coverage for charges or
25 expenses incurred during a specified period following the
26 individual's effective date of coverage, as to a condition for which
27 medical advice, diagnosis, care, or treatment was recommended
28 or received during a specified period immediately preceding the
29 effective date of coverage. For purposes of this section, preexisting
30 condition provisions contained in individual health insurance
31 policies may relate only to conditions for which medical advice,
32 diagnosis, care, or treatment, including use of prescription drugs,
33 was recommended or received from a licensed health practitioner
34 during the 12 months immediately preceding the effective date of
35 coverage.

36 10930. (a) On or before April 1, 2009, the department and the
37 Department of Managed Health Care shall jointly, by regulation,
38 develop a system to categorize all health insurance policies and
39 health plan contracts offered and sold to individuals pursuant to
40 this chapter and Article 11.6 (commencing with Section 1399.820)

1 of Chapter 2.2 of Division 2 of the Health and Safety Code into
 2 five coverage choice categories. These coverage choice categories
 3 shall do all of the following:

4 (1) Reflect a reasonable continuum between the coverage choice
 5 category with the lowest level of health care benefits and the
 6 coverage choice category with the highest level of health care
 7 benefits.

8 (2) Permit reasonable benefit variation that will allow for a
 9 diverse market within each coverage choice category.

10 (3) Be enforced consistently between health insurers and health
 11 plans in the same marketplace regardless of licensure.

12 (4) Within each coverage choice category, include one standard
 13 preferred provider organization (PPO), which is the health
 14 insurance policy with the lowest benefit level in that category and
 15 for that type of contract.

16 (b) All health insurers shall submit the filings required pursuant
 17 to Section 10939 no later than October 1, 2009, for all individual
 18 health insurance policies to be sold on or after July 1, 2010, to
 19 comply with this chapter, and thereafter any additional health
 20 insurance policies shall be filed pursuant to Section 10939. The
 21 commissioner shall categorize each health insurance policy offered
 22 by a health insurer into the appropriate coverage choice category
 23 on or before March 31, 2010.

24 (c) To facilitate consumer comparison shopping, all health
 25 insurers that offer coverage on an individual basis shall offer at
 26 least one health insurance policy in each coverage choice category,
 27 including offering at least one of the standard contracts developed
 28 pursuant to paragraph (4) of subdivision (a), but a health insurer
 29 may offer multiple products in each category.

30 (d) If a health insurer offers a specific type of health insurance
 31 policy in one coverage choice category, it must offer that specific
 32 type of health insurance policy in each coverage choice category.
 33 A “type of health insurance policy” includes a health maintenance
 34 organization model, a preferred provider organization model, an
 35 exclusive provider organization model, a traditional indemnity
 36 model, and a point of service model.

37 (e) Health insurers shall have flexibility in establishing provider
 38 networks, provided that access to care standards pursuant to Section
 39 10133.5 are met, and provided that the provider network offered
 40 for one health insurance policy in one coverage choice category

1 is offered for at least one health insurance policy in each coverage
2 choice category.

3 (f) A health insurer shall establish prices for its products that
4 reflect a reasonable continuum between the products offered in
5 the coverage choice category with the lowest level of benefits and
6 the products offered in the coverage choice category with the
7 highest level of benefits. A health plan shall not establish a standard
8 risk rate for a product in a coverage choice category at a lower rate
9 than a product offered in a lower coverage choice category.

10 (g) The coverage choice category with the lowest level of
11 benefits shall include the benefits that meet the requirements of
12 minimum creditable coverage as determined by the Managed Risk
13 Medical Insurance Board pursuant to Section 12739.50.

14 10931. A health insurer shall offer coverage for a Healthy
15 Action Incentives and Rewards Program that complies with the
16 requirements of Section 10123.56 in at least one health insurance
17 policy in every coverage choice category.

18 10932. When an individual submits a premium payment, based
19 on the quoted premium charges, and that payment is delivered or
20 postmarked, whichever occurs earlier, within the first 15 days of
21 the month, coverage under the health insurance policy shall become
22 effective no later than the first day of the following month. When
23 that payment is either delivered or postmarked after the 15th day
24 of a month, coverage shall become effective no later than the first
25 day of the second month following delivery or postmark of the
26 payment.

27 10933. Except as provided in Section 10928, a health insurer
28 is not required to offer an individual health insurance policy and
29 may reject an application for an individual health insurance policy
30 in the case of either of the following:

31 (a) The individual and dependents who are to be covered by the
32 health insurance policy do not work or reside in a health insurer's
33 approved service area.

34 (b) (1) Within a specific service area or portion of a service
35 area, if a health insurer reasonably anticipates and demonstrates
36 to the satisfaction of the commissioner that it will not have
37 sufficient health care delivery resources to assure that health care
38 services will be available and accessible to the eligible individual
39 and dependents of the individual because of its obligations to
40 existing enrollees.

1 (2) A health insurer that cannot offer a health insurance policy
2 to individuals because it is lacking in sufficient health care delivery
3 resources within a service area or a portion of a service area may
4 not offer a health insurance policy in the area in which the health
5 insurer is not offering coverage to individuals until the health
6 insurer notifies the commissioner that it has the ability to deliver
7 services to new enrollees, and certifies to the commissioner that
8 from the date of the notice it will enroll all individuals and groups
9 requesting coverage in that area from the health insurer.

10 (c) A person who has been a resident of California for six
11 months or less unless one of the following applies: (1) the person
12 is a federally eligible defined individual as defined in Section
13 10785 or Section 1399.801 of the Health and Safety Code; or (2)
14 the person can demonstrate a minimum of two years of prior
15 creditable coverage at least equivalent to the minimum creditable
16 coverage developed by the Managed Risk Medical Insurance Board
17 pursuant to Section 12739.50 and providing the person applies for
18 coverage in California within 62 days of termination or cancellation
19 of the prior creditable coverage.

20 (d) Any person who has been granted a temporary or permanent
21 hardship exemption from the requirement to maintain minimum
22 creditable coverage by the Managed Risk Medical Insurance Board
23 pursuant to subdivision (e) of Section 12739.50, during the time
24 period of the exemption, as determined by the board.

25 10934. (a) If an individual disenrolls from a health insurance
26 policy or health plan contract or if the individual's health insurance
27 policy or health plan contract is canceled pursuant to Section 10936
28 or Section 1399.839 of the Health and Safety Code prior to the
29 anniversary date of the health insurance policy or health plan
30 contract, subsequent enrollment in an individual health insurance
31 policy or individual health plan contract shall be limited to the
32 same coverage choice category the individual was enrolled in prior
33 to disenrollment or cancellation.

34 (b) (1) An individual may change to a health insurance policy
35 in a different coverage choice category only on the anniversary
36 date of the subscriber or upon a qualifying event.

37 (2) In no case, however, may an individual move up more than
38 one coverage choice category on the anniversary date of the
39 subscriber unless there is also a qualifying event.

1 (c) An individual health insurance policy described in
2 subdivision (a) of Section 10925 that does not meet or exceed the
3 minimum health care coverage requirements of Section 12739.50
4 shall be deemed to be the lowest coverage choice category for
5 purposes of this section.

6 (d) On and after January 1, 2011, an individual who fails to
7 comply with the provisions of Chapter 15 (commencing with
8 Section 8899.50) of Division 1 of Title 2 of the Government Code
9 for more than 62 days may only enroll in a health insurance policy
10 or health plan contract in the lowest coverage choice category.
11 Upon the individual's anniversary date, the individual may move
12 to a higher coverage choice category pursuant to subdivision (b).

13 (e) For purposes of this section, a qualifying event occurs upon
14 any of the following:

15 (1) Upon the death of the subscriber, on whose qualifying
16 coverage an individual was a dependent.

17 (2) Upon marriage of the subscriber or entrance by the subscriber
18 into a domestic partnership pursuant to Section 298.5 of the Family
19 Code.

20 (3) Upon divorce or legal separation of an individual from the
21 subscriber.

22 (4) Upon loss of dependent status by a dependent enrolled in
23 group health care coverage through a health care service plan or
24 a health insurer.

25 (5) Upon the birth or adoption of a child.

26 (6) Upon loss of minimum creditable coverage as defined by
27 the Managed Risk Medical Insurance Board pursuant to Section
28 12739.50.

29 10935. The commissioner may require a health insurer to
30 discontinue the offering of policies or acceptance of applications
31 from any individual upon a determination by the commissioner
32 that the health insurer does not have sufficient financial viability,
33 or organizational and administrative capacity to ensure the delivery
34 of health care services to its enrollees.

35 10936. All health insurance policies offered pursuant to this
36 chapter shall be renewable with respect to all individuals and
37 dependents at the option of the subscriber and shall not be canceled
38 except for the following reasons:

39 (a) Failure to pay any charges for coverage provided pursuant
40 to the contract if the subscriber has been duly notified and billed

1 for those charges and at least 15 days has elapsed since the date
2 of notification.

3 (b) Fraud or intentional misrepresentation of material fact under
4 the terms of the health insurance policy by the individual.

5 (c) Fraud or deception in the use of the services or facilities of
6 the health insurer or knowingly permitting that fraud or deception
7 by another.

8 (d) Movement of the subscriber outside the health insurer's
9 service area.

10 (e) If the health insurer ceases to provide or arrange for the
11 provision of health care services for new or existing individual
12 health insurance policies in this state, provided, however, that the
13 following conditions are satisfied:

14 (1) Notice of the decision to cease new or existing individual
15 health insurance policies in the state is provided to the
16 commissioner and to the individual at least 180 days prior to
17 discontinuation of that coverage.

18 (2) Individual health insurance policies shall not be canceled
19 for 180 days after the date of the notice required under paragraph
20 (1) and for that business of a health insurer that remains in force,
21 any health insurer that ceases to offer for sale new individual health
22 insurance policies shall continue to be governed by this chapter
23 with respect to business conducted under this chapter.

24 (3) A health insurer that ceases to write new individual health
25 insurance policies in this state after the effective date of this section
26 shall be prohibited from offering for sale individual health
27 insurance policies in this state for a period of five years from the
28 date of notice to the commissioner. The commissioner may permit
29 a health insurer to offer and sell individual health insurance policies
30 in this state before the five-year time period has expired if the
31 commissioner determines that it is in the best interest of the state
32 and necessary to preserve the integrity of the health care market.

33 (f) If the health insurer withdraws an individual health insurance
34 policy from the market, provided that the health insurer notifies
35 all affected individuals and the commissioner at least 90 days prior
36 to the discontinuation of these health insurance policies, and that
37 the health insurer makes available to the individual all health
38 insurance policies with comparable benefits that it makes available
39 to new individual business.

1 (g) On or after July 1, 2010, a health insurer shall not rescind
2 the health insurance policy of any individual.

3 (h) Nothing in this article shall limit any other remedies available
4 at law to a health insurer.

5 10937. Premiums for health insurance policies offered or
6 delivered by health insurers on or after the effective date of this
7 chapter shall be subject to the following requirements:

8 (a) The premium for new or existing business shall be the
9 standard risk rate for an individual in a particular risk category.

10 (b) The premium rates shall be in effect for no less than 12
11 months from the date of the health insurance policy.

12 (c) When determining the premium rate for more than one
13 covered individual, the health insurer shall determine the rate based
14 on the standard risk rate for the subscriber. If more than one
15 individual is a subscriber, the premium rate shall be based on the
16 age of the youngest spouse or registered domestic partner.

17 (d) (1) Notwithstanding subdivision (a), for the first two years
18 following the implementation of this section, a health insurer may
19 apply a risk adjustment factor to the standard risk rate that may
20 not be more than 120 percent or less than 80 percent of the
21 applicable standard risk rate. In determining the risk adjustment
22 factor, a health insurer shall use the standardized form and process
23 developed by the Director of the Department of Managed Health
24 Care pursuant to subdivision (f) of Section 1399.840 of the Health
25 and Safety Code.

26 (2) After the first two years following the implementation of
27 this section, the adjustments applicable under paragraph (1) shall
28 not be more than 110 percent or less than 90 percent of the standard
29 risk rate.

30 (3) Upon the renewal of any contract, the risk adjustment factor
31 applied to the individual's rate may not be more than 5 percentage
32 points different than the factor applied to that rate prior to renewal.
33 The same limitation shall be applied to individuals with respect to
34 the risk adjustment factor applicable for the purchase of a new
35 product where the individual's prior health insurer has discontinued
36 that product.

37 (4) After the first four years following the implementation of
38 this section, a health insurer shall base rates on the standard risk
39 rate with no risk adjustment factor.

1 (e) The commissioner and the Director of the Department of
2 Managed Health Care shall jointly establish a maximum limit on
3 the ratio between the standard risk rates for contracts for individuals
4 in the 60 to 64 years of age, inclusive, category and contracts for
5 individuals in the 30 to 34 years of age, inclusive, category.

6 10938. (a) In connection with the offering for sale of any health
7 insurance policy to an individual, each health insurer shall make
8 a reasonable disclosure, as part of its solicitation and sales
9 materials, of all of the following:

10 (1) The provisions concerning the health insurer's right to
11 change premium rates on an annual basis and the factors other than
12 provision of services experience that affect changes in premium
13 rates.

14 (2) Provisions relating to the guaranteed issue and renewal of
15 individual health insurance policies.

16 (3) Provisions relating to the individual's right to obtain any
17 health insurance policy the individual is eligible to enroll in
18 pursuant to Sections 10928 and 10934.

19 (4) The availability, upon request, of a listing of all the
20 individual health insurance policies offered by the health insurer,
21 including the rates for each health insurance policy.

22 (b) Every solicitor or solicitor firm contracting with one or more
23 health insurers to solicit enrollments or subscriptions from
24 individuals shall, when providing information on health insurance
25 policies to an individual but making no specific recommendations
26 on particular health insurance policies, do both of the following:

27 (1) Advise the individual of the health insurer's obligation to
28 sell to any individual any health insurance policy it offers to
29 individuals and provide him or her, upon request, with the actual
30 rates that would be charged to that individual for a given health
31 insurance policy.

32 (2) Notify the individual that the solicitor or solicitor firm will
33 procure rate and benefit information for the individual on any
34 health insurance policy offered by a health insurer whose policy
35 the solicitor sells.

36 (c) Prior to filing an application for a particular individual health
37 insurance policy, the health insurer shall obtain a signed statement
38 from the individual acknowledging that the individual has received
39 the disclosures required by this section.

1 10939. (a) At least 20 business days prior to offering a health
2 insurance policy subject to this chapter, all health insurers shall
3 file with the commissioner a statement certifying that the health
4 insurer is in compliance with Sections 10920 and 10937. The
5 certified statement shall set forth the standard risk rate for each
6 risk category that will be used in setting the rates at which the
7 contract will be offered. Any action by the commissioner to
8 disapprove, suspend, or postpone the health insurer's use of a
9 health insurance policy shall be in writing, specifying the reasons
10 that the health insurance policy does not comply with the
11 requirements of this chapter.

12 (b) Prior to making any changes in the standard risk rates filed
13 with the commissioner pursuant to subdivision (a), the health
14 insurer shall file as an amendment a statement setting forth the
15 changes and certifying that the health insurer is in compliance with
16 Sections 10920 and 10937. If the standard risk rate is being
17 changed, a health insurer may commence offering health insurance
18 policies utilizing the changed standard risk rate upon filing the
19 certified statement unless the commissioner disapproves the
20 amendment by written notice.

21 (c) Periodic changes to the standard risk rate that a health insurer
22 proposes to implement over the course of up to 12 consecutive
23 months may be filed in conjunction with the certified statement
24 filed under subdivision (a) or (b).

25 (d) Each health insurer shall maintain at its principal place of
26 business all of the information required to be filed with the
27 commissioner pursuant to this chapter.

28 (e) This section shall become operative on July 1, 2009.

29 10940. (a) A health insurer shall include all of the following
30 in the statement filed pursuant to subdivision (a) of Section 10939:

31 (1) A summary explanation of the following for each health
32 insurance policy offered to individuals:

33 (A) Eligibility requirements.

34 (B) The full premium cost of each health insurance policy in
35 each risk category, as defined in subdivision (k) of Section 10920.

36 (C) When and under what circumstances benefits cease.

37 (D) Other coverage that may be available if benefits under the
38 described health insurance policy cease.

39 (E) The circumstances under which choice in the selection of
40 physicians and providers is permitted.

1 (F) Deductibles.

2 (G) Annual out-of-pocket maximums.

3 (2) A summary explanation of coverage for the following,
4 together with the corresponding copayments, coinsurance, and
5 applicable limitations for each health insurance policy offered to
6 individuals:

7 (A) Professional services.

8 (B) Outpatient services.

9 (C) Preventive services.

10 (D) Hospitalization services.

11 (E) Emergency health coverage.

12 (F) Ambulance services.

13 (G) Prescription drug coverage.

14 (H) Durable medical equipment.

15 (I) Mental health and substance abuse services.

16 (J) Home health services.

17 (3) The telephone number or numbers that may be used by an
18 applicant to access a health insurer customer service representative
19 to request additional information about the health insurance policy.

20 (b) If any information provided pursuant to subdivision (a)
21 changes, the health insurer shall provide to the commissioner, on
22 an annual basis, an update of that information.

23 10941. The commissioner shall share the information provided
24 by health insurers pursuant to this article with the Office of the
25 Patient Advocate for purposes of the development, creation, and
26 maintenance of the comparative benefits matrix described in
27 Section 1399.834 of the Health and Safety Code.

28 10943. (a) The commissioner may issue regulations that are
29 necessary to carry out the purposes of this chapter.

30 (b) Nothing in this chapter shall be construed as providing the
31 commissioner with rate regulation authority.

32 10944. Sections 10922, 10925, and 10930 shall become
33 operative on January 1, 2009, and Section 10939 shall become
34 operative on July 1, 2009. All remaining sections of this chapter
35 shall become operative on July 1, 2010.

36 SEC. 43. Section 12693.43 of the Insurance Code is amended
37 to read:

38 12693.43. (a) Applicants applying to the purchasing pool shall
39 agree to pay family contributions, unless the applicant has a family

1 contribution sponsor. Family contribution amounts consist of the
2 following two components:

3 (1) The flat fees described in subdivision (b) or (d).

4 (2) Any amounts that are charged to the program by participating
5 health, dental, and vision plans selected by the applicant that exceed
6 the cost to the program of the highest cost family value package
7 in a given geographic area.

8 (b) In each geographic area, the board shall designate one or
9 more family value packages for which the required total family
10 contribution is:

11 (1) Seven dollars (\$7) per child with a maximum required
12 contribution of fourteen dollars (\$14) per month per family for
13 applicants with annual household incomes up to and including 150
14 percent of the federal poverty level.

15 (2) Nine dollars (\$9) per child with a maximum required
16 contribution of twenty-seven dollars (\$27) per month per family
17 for applicants with annual household incomes greater than 150
18 percent and up to and including 200 percent of the federal poverty
19 level and for applicants on behalf of children described in clause
20 (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of
21 Section 12693.70.

22 (3) On and after July 1, 2005, fifteen dollars (\$15) per child
23 with a maximum required contribution of forty-five dollars (\$45)
24 per month per family for applicants with annual household income
25 to which subparagraph (B) of paragraph (6) of subdivision (a) of
26 Section 12693.70 is applicable. Notwithstanding any other
27 provision of law, if an application with an effective date prior to
28 July 1, 2005, was based on annual household income to which
29 subparagraph (B) of paragraph (6) of subdivision (a) of Section
30 12693.70 is applicable, then this paragraph shall be applicable to
31 the applicant on July 1, 2005, unless subparagraph (B) of paragraph
32 (6) of subdivision (a) of Section 12693.70 is no longer applicable
33 to the relevant family income. The program shall provide prior
34 notice to any applicant for currently enrolled subscribers whose
35 premium will increase on July 1, 2005, pursuant to this paragraph
36 and, prior to the date the premium increase takes effect, shall
37 provide that applicant with an opportunity to demonstrate that
38 subparagraph (B) of paragraph (6) of subdivision (a) of Section
39 12693.70 is no longer applicable to the relevant family income.
40 On and after July 1, 2009, this paragraph shall only apply to

1 individuals to which clause (i), but not clause (ii), of subparagraph
2 (B) of paragraph (6) of subdivision (a) of Section 12693.70 is
3 applicable.

4 (4) On and after July 1, 2009, twenty-five dollars (\$25) per child
5 with a maximum required contribution of seventy-five dollars
6 (\$75) per month per family for applicants with annual household
7 income to which clause (ii) of subparagraph (B) of paragraph (6)
8 of subdivision (a) of Section 12693.70 is applicable.

9 (c) Combinations of health, dental, and vision plans that are
10 more expensive to the program than the highest cost family value
11 package may be offered to and selected by applicants. However,
12 the cost to the program of those combinations that exceeds the
13 price to the program of the highest cost family value package shall
14 be paid by the applicant as part of the family contribution.

15 (d) The board shall provide a family contribution discount to
16 those applicants who select the health plan in a geographic area
17 that has been designated as the Community Provider Plan. The
18 discount shall reduce the portion of the family contribution
19 described in subdivision (b) to the following:

20 (1) A family contribution of four dollars (\$4) per child with a
21 maximum required contribution of eight dollars (\$8) per month
22 per family for applicants with annual household incomes up to and
23 including 150 percent of the federal poverty level.

24 (2) Six dollars (\$6) per child with a maximum required
25 contribution of eighteen dollars (\$18) per month per family for
26 applicants with annual household incomes greater than 150 percent
27 and up to and including 200 percent of the federal poverty level
28 and for applicants on behalf of children described in clause (ii) of
29 subparagraph (A) of paragraph (6) of subdivision (a) of Section
30 12693.70.

31 (3) On and after July 1, 2005, twelve dollars (\$12) per child
32 with a maximum required contribution of thirty-six dollars (\$36)
33 per month per family for applicants with annual household income
34 to which subparagraph (B) of paragraph (6) of subdivision (a) of
35 Section 12693.70 is applicable. Notwithstanding any other
36 provision of law, if an application with an effective date prior to
37 July 1, 2005, was based on annual household income to which
38 subparagraph (B) of paragraph (6) of subdivision (a) of Section
39 12693.70 is applicable, then this paragraph shall be applicable to
40 the applicant on July 1, 2005, unless subparagraph (B) of paragraph

1 (6) of subdivision (a) of Section 12693.70 is no longer applicable
2 to the relevant family income. The program shall provide prior
3 notice to any applicant for currently enrolled subscribers whose
4 premium will increase on July 1, 2005, pursuant to this paragraph
5 and, prior to the date the premium increase takes effect, shall
6 provide that applicant with an opportunity to demonstrate that
7 subparagraph (B) of paragraph (6) of subdivision (a) of Section
8 12693.70 is no longer applicable to the relevant family income.
9 On and after July 1, 2009, this paragraph shall only apply to
10 individuals to which clause (i) but not clause (ii) of subparagraph
11 (B) of paragraph (6) of subdivision (a) of Section 12693.70 is
12 applicable.

13 (4) On and after July 1, 2009, twenty-two dollars (\$22) with a
14 maximum required contribution of sixty-six dollars (\$66) per month
15 per family for applicants with annual household income to which
16 clause (ii) of subparagraph (B) of paragraph (6) of subdivision (a)
17 of Section 12693.70 is applicable.

18 (e) Applicants, but not family contribution sponsors, who pay
19 three months of required family contributions in advance shall
20 receive the fourth consecutive month of coverage with no family
21 contribution required.

22 (f) Applicants, but not family contribution sponsors, who pay
23 the required family contributions by an approved means of
24 electronic fund transfer shall receive a 25-percent discount from
25 the required family contributions.

26 (g) It is the intent of the Legislature that the family contribution
27 amounts described in this section comply with the premium cost
28 sharing limits contained in Section 2103 of Title XXI of the Social
29 Security Act. If the amounts described in subdivision (a) are not
30 approved by the federal government, the board may adjust these
31 amounts to the extent required to achieve approval of the state
32 plan.

33 (h) The adoption and one readoption of regulations to implement
34 paragraph (3) of subdivision (b) and paragraph (3) of subdivision
35 (d) shall be deemed to be an emergency and necessary for the
36 immediate preservation of public peace, health, and safety, or
37 general welfare for purposes of Sections 11346.1 and 11349.6 of
38 the Government Code, and the board is hereby exempted from the
39 requirement that it describe specific facts showing the need for
40 immediate action and from review by the Office of Administrative

1 Law. For purposes of subdivision (e) of Section 11346.1 of the
2 Government Code, the 120-day period, as applicable to the
3 effective period of an emergency regulatory action and submission
4 of specified materials to the Office of Administrative law, is hereby
5 extended to 180 days.

6 SEC. 44. Section 12693.56 is added to the Insurance Code, to
7 read:

8 12693.56. (a) The board may provide or arrange for the
9 provision of an electronic personal health record for enrollees
10 receiving health care benefits, to the extent funds are appropriated
11 for this purpose. The record shall be provided for the purpose of
12 providing enrollees with information to assist them in
13 understanding their coverage benefits and managing their health
14 care.

15 (b) At a minimum, the personal health record shall provide
16 access to real-time, patient-specific information regarding
17 eligibility for covered benefits and cost sharing requirements. The
18 access may be provided through the use of an Internet-based
19 system.

20 (c) In addition to the data required pursuant to subdivision (b),
21 the board may determine that the personal health record shall also
22 incorporate additional data, including, but not limited to, laboratory
23 results, prescription history, claims history, and personal health
24 information authorized or provided by the enrollee. Inclusion of
25 this additional data shall be at the option of the enrollee.

26 (d) Systems or software that pertain to the personal health record
27 shall adhere to accepted national standards for interoperability,
28 privacy, and data exchange, or shall be certified by a nationally
29 recognized certification body.

30 (e) The personal health record shall comply with applicable
31 state and federal confidentiality and data security requirements.

32 SEC. 45. Section 12693.57 is added to the Insurance Code, to
33 read:

34 12693.57. Every person administering or providing benefits
35 under the program shall not elicit any information from the
36 applicant or subscriber that is not required to carry out the
37 provisions of law applicable to the program.

38 SEC. 46. Section 12693.58 is added to the Insurance Code, to
39 read:

1 12693.58. (a) All types of information, whether written or
2 oral, concerning an applicant, subscriber, or household member,
3 made or kept by any public officer or agency in connection with
4 the administration of any provision of this part shall be confidential,
5 and shall not be open to examination other than for purposes
6 directly connected with the administration of the Healthy Families
7 Program or the Medi-Cal program.

8 (b) Except as provided in this section and to the extent permitted
9 by federal law or regulation, all information about applicants,
10 subscribers, and household members to be safeguarded as provided
11 for in subdivision (a) includes, but is not limited to, names and
12 addresses, medical services provided, social and economic
13 conditions or circumstances, agency evaluation of personal
14 information, and medical data, including diagnosis and past history
15 of disease or disability.

16 (c) Purposes directly connected with the administration of the
17 Healthy Families Program encompass all activities and
18 responsibilities in which the Managed Risk Medical Insurance
19 Board and its agents, officers, trustees, employees, consultants,
20 and contractors are engaged to conduct program operations.
21 Purposes directly connected with the administration of the
22 Medi-Cal program encompass all activities and responsibilities in
23 which the State Department of Health Care Services and its agents,
24 officers, trustees, employees, consultants, and contractors are
25 engaged to conduct program operations.

26 (d) Nothing in this section shall be construed to prohibit the
27 disclosure of information about the applicant, subscriber, or
28 household member when the applicant, subscriber, or household
29 member to whom the information pertains or the parent or adult
30 with legal custody provides express written authorization.

31 (e) Nothing in this part shall prohibit the disclosure of protected
32 health information as provided in Section 164.512 of Title 45 of
33 the Code of Federal Regulations.

34 (f) In the event of a conflict between this section and Section
35 14100.2 of the Welfare and Institutions Code, the latter section
36 shall control.

37 SEC. 47. Section 12693.59 is added to the Insurance Code, to
38 read:

39 12693.59. Nothing in this part shall preclude the board from
40 soliciting voluntary participation by applicants and subscribers in

1 communicating with the board, or with any other party, concerning
 2 their needs as well as the needs of others who are not adequately
 3 covered by existing private and public health care delivery systems
 4 or concerning means of ensuring the availability of adequate health
 5 care services. The board shall inform applicants and subscribers
 6 that their participation is voluntary and shall inform them of the
 7 uses for which the information is intended.

8 SEC. 48. Section 12693.70 of the Insurance Code is amended
 9 to read:

10 12693.70. To be eligible to participate in the program, an
 11 applicant shall meet all of the following requirements:

12 (a) Be an applicant applying on behalf of an eligible child, which
 13 means a child who is all of the following:

14 (1) Less than 19 years of age. An application may be made on
 15 behalf of a child not yet born up to three months prior to the
 16 expected date of delivery. Coverage shall begin as soon as
 17 administratively feasible, as determined by the board, after the
 18 board receives notification of the birth. However, no child less
 19 than 12 months of age shall be eligible for coverage until 90 days
 20 after the enactment of the Budget Act of 1999.

21 (2) Not eligible for no-cost full-scope Medi-Cal or Medicare
 22 coverage at the time of application.

23 (3) In compliance with Sections 12693.71 and 12693.72.

24 (4) A child who meets citizenship and immigration status
 25 requirements that are applicable to persons participating in the
 26 program established by Title XXI of the Social Security Act, except
 27 as specified in Section 12693.76.

28 (5) A resident of the State of California pursuant to Section 244
 29 of the Government Code; or, if not a resident pursuant to Section
 30 244 of the Government Code, is physically present in California
 31 and entered the state with a job commitment or to seek
 32 employment, whether or not employed at the time of application
 33 to or after acceptance in, the program.

34 (6) (A) In either of the following:

35 (i) In a family with an annual or monthly household income
 36 equal to or less than 200 percent of the federal poverty level.

37 (ii) When implemented by the board, subject to subdivision (b)
 38 of Section 12693.765 and pursuant to this section, a child under
 39 the age of two years who was delivered by a mother enrolled in
 40 the Access for Infants and Mothers Program as described in Part

1 6.3 (commencing with Section 12695). Commencing July 1, 2007,
2 eligibility under this subparagraph shall not include infants during
3 any time they are enrolled in employer-sponsored health insurance
4 or are subject to an exclusion pursuant to Section 12693.71 or
5 12693.72, or are enrolled in the full scope of benefits under the
6 Medi-Cal program at no share of cost. For purposes of this clause,
7 any infant born to a woman whose enrollment in the Access for
8 Infants and Mothers Program begins after June 30, 2004, shall be
9 automatically enrolled in the Healthy Families Program, except
10 during any time on or after July 1, 2007, that the infant is enrolled
11 in employer-sponsored health insurance or is subject to an
12 exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled
13 in the full scope of benefits under the Medi-Cal program at no
14 share of cost. Except as otherwise specified in this section, this
15 enrollment shall cover the first 12 months of the infant's life. At
16 the end of the 12 months, as a condition of continued eligibility,
17 the applicant shall provide income information. The infant shall
18 be disenrolled if the gross annual household income exceeds the
19 income eligibility standard that was in effect in the Access for
20 Infants and Mothers Program at the time the infant's mother
21 became eligible, or following the two-month period established
22 in Section 12693.981 if the infant is eligible for Medi-Cal with no
23 share of cost. At the end of the second year, infants shall again be
24 screened for program eligibility pursuant to this section, with
25 income eligibility evaluated pursuant to clause (i), subparagraphs
26 (B) and (C), and paragraph (2) of subdivision (a).

27 (B) (i) All income over 200 percent of the federal poverty level
28 but less than or equal to 250 percent of the federal poverty level
29 shall be disregarded in calculating annual or monthly household
30 income.

31 (ii) On and after July 1, 2009, all income over 250 percent of
32 the federal poverty level but less than or equal to 300 percent of
33 the federal poverty level shall also be disregarded in calculating
34 annual or monthly household income.

35 (C) Prior to July 1, 2009, in a family with an annual or monthly
36 household income greater than 250 percent of the federal poverty
37 level, any income deduction that is applicable to a child under
38 Medi-Cal shall be applied in determining the annual or monthly
39 household income. If the income deductions reduce the annual or

1 monthly household income to 250 percent or less of the federal
2 poverty level, subparagraph (B) shall be applied.

3 (D) On and after July 1, 2009, in a family with an annual or
4 monthly household income greater than 300 percent of the federal
5 poverty level, any income deduction that is applicable to a child
6 under Medi-Cal shall be applied in determining the annual or
7 monthly household income. If the income deductions reduce the
8 annual or monthly household income to 300 percent or less of the
9 federal poverty level, subparagraph (B) shall be applied.

10 (b) The applicant shall agree to remain in the program for six
11 months, unless other coverage is obtained and proof of the coverage
12 is provided to the program.

13 (c) An applicant shall enroll all of the applicant’s eligible
14 children in the program.

15 (d) In filing documentation to meet program eligibility
16 requirements, if the applicant’s income documentation cannot be
17 provided, as defined in regulations promulgated by the board, the
18 applicant’s signed statement as to the value or amount of income
19 shall be deemed to constitute verification.

20 (e) An applicant shall pay in full any family contributions owed
21 in arrears for any health, dental, or vision coverage provided by
22 the program within the prior 12 months.

23 (f) By January 2008, the board, in consultation with
24 stakeholders, shall implement processes by which applicants for
25 subscribers may certify income at the time of annual eligibility
26 review, including rules concerning which applicants shall be
27 permitted to certify income and the circumstances in which
28 supplemental information or documentation may be required. The
29 board may terminate using these processes not sooner than 90 days
30 after providing notification to the Chair of the Joint Legislative
31 Budget Committee. This notification shall articulate the specific
32 reasons for the termination and shall include all relevant data
33 elements that are applicable to document the reasons for the
34 termination. Upon the request of the Chair of the Joint Legislative
35 Budget Committee, the board shall promptly provide any additional
36 clarifying information regarding implementation of the processes
37 required by this subdivision.

38 SEC. 49. Section 12693.73 of the Insurance Code is amended
39 to read:

1 12693.73. (a) Notwithstanding any other provision of law,
2 children excluded from coverage under Title XXI of the Social
3 Security Act are not eligible for coverage under the program, except
4 as specified in clause (ii) of subparagraph (A) of paragraph (6) of
5 subdivision (a) of Section 12693.70 and Section 12693.76.

6 (b) On and after July 1, 2009, children who otherwise meet
7 eligibility requirements for the program but for their immigration
8 status are eligible for the program.

9 SEC. 50. Section 12693.76 of the Insurance Code is amended
10 to read:

11 12693.76. (a) Notwithstanding any other provision of law, a
12 child who is a qualified alien as defined in Section 1641 of Title
13 8 of the United States Code Annotated shall not be determined
14 ineligible solely on the basis of his or her date of entry into the
15 United States.

16 (b) Notwithstanding any other provision of law, subdivision (a)
17 may only be implemented to the extent provided in the annual
18 Budget Act.

19 (c) Notwithstanding any other provision of law, any uninsured
20 parent or responsible adult who is a qualified alien, as defined in
21 Section 1641 of Title 8 of the United States Code, shall not be
22 determined to be ineligible solely on the basis of his or her date
23 of entry into the United States.

24 (d) Notwithstanding any other provision of law, subdivision (c)
25 may only be implemented to the extent of funding provided in the
26 annual Budget Act.

27 (e) Notwithstanding any other provision of law, on and after
28 July 1, 2009, a child who is otherwise eligible to participate in the
29 program shall not be determined ineligible solely on the basis of
30 his or her immigration status.

31 SEC. 51. Section 12693.766 is added to the Insurance Code,
32 to read:

33 12693.766. (a) To establish that the individual meets the
34 requirements under subdivision (b) of Section 12693.73 and
35 subdivision (e) of Section 12693.76, the parent or caretaker relative
36 shall sign under penalty of perjury an attestation that the individual
37 is not described in any of the categories enumerated on the
38 attestation for which federal financial participation for full-scope
39 services is available.

1 (b) In implementing this section, the board shall consult with
2 stakeholders, including, but not limited to, consumer advocates
3 and counties.

4 (c) Nothing in this section shall be construed to limit a child’s
5 access to Medi-Cal or Healthy Families eligibility under existing
6 law.

7 (d) This section shall become operative July 1, 2009.

8 SEC. 53. Part 6.45 (commencing with Section 12699.201) is
9 added to Division 2 of the Insurance Code, to read:

10

11 PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH
12 INSURANCE PURCHASING PROGRAM

13

14 CHAPTER 1. GENERAL PROVISIONS

15

16 12699.201. For the purposes of this part, the following terms
17 have the following meanings:

18

19 (a) “Benefit plan design” means a specific health coverage
20 product offered for sale and includes services covered and the
21 levels of copayments, deductibles, and annual out-of-pocket
22 expenses, and may include the professional providers who are to
23 provide those services and the sites where those services are to be
24 provided. A benefit plan design may also be an integrated system
25 for the financing and delivery of quality health care services that
26 has significant incentives for the covered individuals to use the
27 system.

27

(b) “Board” means the Managed Risk Medical Insurance Board.

28

29 (c) “California Cooperative Health Insurance Purchasing
30 Program” or “Cal-CHIPP” means the statewide purchasing pool
31 established pursuant to this part and administered by the board.

31

32 (d) “Dependent” means the spouse, child, or registered domestic
33 partner of an individual, subject to applicable terms of the health
34 plan contract covering the individual.

34

35 (e) “Enrollee” means an individual who is eligible for, and
36 participates in, Cal-CHIPP.

36

37 (f) “Fund” means the California Health Trust Fund established
38 pursuant to Section 12699.212.

38

39 (g) “Cal-CHIPP Healthy Families plan” shall mean health care
40 coverage provided through a health care service plan or a health
insurer that provides for individuals eligible pursuant to Section

1 12699.211.01 of the Insurance Code, or Section 14005.301 or
2 14005.305 of the Welfare and Institutions Code, coverage that, at
3 a minimum, provides the same covered services and benefits
4 required under the Knox-Keene Health Care Service Plan Act of
5 1975 (Chapter 2.2 (commencing with Section 1340) of Division
6 2 of the Health and Safety Code) plus prescription drug benefits.
7 Prescription drug benefits shall, at minimum, provide coverage
8 for outpatient generic prescription drugs and brand name drugs
9 when a prescription drug that is prescribed has no generic
10 equivalent or when an individual is unable to achieve the desired
11 therapeutic result with a generic drug. Prescription drug coverage
12 may be subject to utilization controls.

13 (h) “Participating dental plan” means either a dental insurer
14 holding a valid certificate of authority from the commissioner or
15 a specialized health care service plan, as defined by subdivision
16 (o) of Section 1345 of the Health and Safety Code, that contracts
17 with the board to provide or to sell dental coverage to enrollees.

18 (i) “Participating health plan” means either a private health
19 insurer holding a valid outstanding certificate of authority from
20 the commissioner or a health care service plan as defined under
21 subdivision (f) of Section 1345 of the Health and Safety Code that
22 contracts with the board to provide or to sell coverage in
23 Cal-CHIPP and, pursuant to its contract with the board, provides,
24 arranges, pays for, or reimburses the costs of health services for
25 Cal-CHIPP enrollees.

26 (j) “Participating vision care plan” means either an insurer
27 holding a valid certificate of authority from the commissioner that
28 issues vision-only coverage or a specialized health care service
29 plan, as defined by subdivision (o) of Section 1345 of the Health
30 and Safety Code, that contracts with the board to provide or to sell
31 vision coverage to enrollees.

32

33 CHAPTER 2. ADMINISTRATION

34

35 12699.202. (a) The board shall be responsible for establishing
36 Cal-CHIPP and administering this part.

37 (b) The board may do all of the following consistent with the
38 standards of this part:

39 (1) Determine eligibility, enrollment, and disenrollment criteria
40 and processes for Cal-CHIPP consistent with the eligibility

- 1 standards in Chapter 3 (commencing with Section 12699.211) and,
- 2 for Cal-CHIPP Healthy Families plan enrollees, the enrollment
- 3 process developed pursuant to Section 12699.211.04.
- 4 (2) Determine the participation requirements for enrollees.
- 5 (3) Determine the participation requirements and the standards
- 6 and selection criteria for participating health, dental, and vision
- 7 care plans, including reasonable limits on a plan’s administrative
- 8 costs.
- 9 (4) Determine when an enrollee’s coverage commences and the
- 10 extent and scope of coverage.
- 11 (5) Determine premium schedules, collect the premiums, and
- 12 administer subsidies to eligible enrollees.
- 13 (6) Determine rates paid to participating health, dental, and
- 14 vision care plans.
- 15 (7) Provide, or make available, coverage through participating
- 16 health plans in Cal-CHIPP.
- 17 (8) Provide, or make available, coverage through participating
- 18 dental and vision care plans in Cal-CHIPP.
- 19 (9) Provide for the processing of applications and the enrollment
- 20 and disenrollment of enrollees.
- 21 (10) Determine and approve the benefit designs and cost-sharing
- 22 provisions for participating health, dental, and vision care plans.
- 23 (11) Enter into contracts.
- 24 (12) Sue and be sued.
- 25 (13) Employ necessary staff.
- 26 (14) Authorize expenditures, as necessary, from the fund to pay
- 27 program expenses that exceed enrollee contributions and to
- 28 administer Cal-CHIPP.
- 29 (15) Issue rules and regulations, as necessary.
- 30 (16) Maintain enrollment and expenditures to ensure that
- 31 expenditures do not exceed the amount of revenue available in the
- 32 fund, and if sufficient revenue is not available to pay the estimated
- 33 expenditures, the board shall institute appropriate measures to
- 34 ensure fiscal solvency. This paragraph shall not be construed to
- 35 allow the board to deny enrollment of a person who otherwise
- 36 meets the eligibility requirements of Chapter 3 (commencing with
- 37 Section 12699.211) in order to ensure the fiscal solvency of the
- 38 fund.
- 39 (17) Establish the criteria and procedures through which
- 40 employers direct employees’ premium dollars, withheld under the

1 terms of a cafeteria plan pursuant to Section 4801 of the
2 Unemployment Insurance Code, to Cal-CHIPP to be credited
3 against the employees' premium obligations.

4 (18) Share information obtained pursuant to this part with the
5 Employment Development Department solely for the purpose of
6 the administration and enforcement of this part.

7 (19) Exercise all powers reasonably necessary to carry out the
8 powers and responsibilities expressly granted or imposed by this
9 part.

10 12699.203. In developing the benefit plan designs, the board
11 shall comply with all of the following:

12 (a) The board shall take into consideration the levels of health
13 care coverage provided in the state and medical economic factors
14 as may be deemed appropriate.

15 (b) The Cal-CHIPP Healthy Families plan shall meet the
16 requirements of the Knox-Keene Health Care Service Plan Act of
17 1975 (Chapter 2.2 (commencing with Section 1340) of Division
18 2 of the Health and Safety Code), and shall include prescription
19 drug benefits, combined with enrollee cost-sharing levels that
20 promote prevention and health maintenance, including appropriate
21 cost-sharing for physician office visits, diagnostic laboratory
22 services, and maintenance medications to manage chronic diseases.
23 Prescription drug benefits shall, at minimum, provide coverage
24 for outpatient generic prescription drugs and brand name drugs
25 when a prescription drug that is prescribed has no generic
26 equivalent or when an individual is unable to achieve the desired
27 therapeutic result with a generic drug. Prescription drug coverage
28 may be subject to utilization controls.

29 (c) For individuals ineligible for a Cal-CHIPP Healthy Families
30 plan, the board shall make available, at a minimum, one product
31 that offers the same benefits as the minimum health care coverage
32 defined in Section 12739.50 and one product each from coverage
33 choice categories 3 and 5, established pursuant to Section 10930
34 and Section 1399.832 of the Health and Safety Code.
35 Notwithstanding Section 1399.828 of the Health and Safety Code
36 and Section 10927, this coverage shall be subject to the same rules
37 as set forth in Article 11.6 (commencing with Section 1399.820)
38 of Chapters 2.2 of Division 2 of the Health and Safety Code or as
39 set forth in Chapter 9.6 (commencing with Section 10919) of Part
40 2.

1 (d) The board may make available, through the program, dental
2 and vision coverage for individuals eligible for and enrolled in
3 other health benefit coverage through the pool under this part, if
4 the board makes all of the following determinations:

5 (1) Making that coverage available will provide a significant
6 benefit for the health coverage marketplace in the state.

7 (2) Making that coverage available will be cost effective.

8 (3) The board can make that coverage available on a guarantee
9 issue basis without undue risk of adverse selection.

10 (e) In determining enrollee and dependent cost-sharing for the
11 Cal-CHIPP Healthy Families plan, the board shall consider whether
12 those costs would deter an enrollee or his or her dependents from
13 obtaining appropriate and timely care, including those enrollees
14 with a low-or-moderate family income. The board shall also
15 consider the impact of these costs on an enrollee’s ability to afford
16 health care services.

17 (f) The board shall consult with the Insurance Commissioner,
18 the Director of the Department of Managed Health Care, and the
19 Director of Health Care Services. As a condition of eligibility for
20 the Cal-CHIPP Healthy Families plan, enrollees shall provide all
21 necessary information and documentation to meet the minimum
22 federal requirements necessary for federal claiming.

23 12699.204. (a) The board may adjust premiums at a public
24 meeting of the board after providing, at minimum, 60 days’ public
25 notice of the adjustment. In making the adjustment, the board shall
26 take into account the costs of health care typically paid for by
27 employers and employees in California.

28 (b) The following premiums shall apply to coverage under this
29 part for the population eligible for coverage pursuant to Section
30 12699.211.01 of the Insurance Code and Sections 14005.301 and
31 14005.305 of the Welfare and Institutions Code.

32 (1) For individuals with a family income less than or equal to
33 150 percent of the federal poverty level, no premiums or
34 out-of-pocket costs shall be allowed.

35 (2) For individuals with a family income above 150 percent but
36 less than or equal to 250 percent of the federal poverty level
37 premiums shall not exceed 5 percent of the family income net of
38 applicable deductions.

39 (c) For health care coverage made available pursuant to this
40 part for enrollees ineligible for a Cal-CHIPP Healthy Families

1 plan, the applicable premiums shall be commensurate with the full
2 premium cost of the coverage choice made by the enrollee.
3 However, enrollees eligible for the state health care tax credit
4 established pursuant to Section 17052.30 of the Revenue and
5 Taxation Code may reduce their premiums by the value of the
6 credit. The board shall provide an additional contribution equal to
7 20 percent of the premium of a tier 1 product in the pool, at a
8 minimum, to employees with incomes at or above 250 percent of
9 the federal poverty level whose employers pay into the fund *and*
10 *where the individual is not enrolled in or eligible for health*
11 *expenditures that may be credited against any required employer*
12 *health care contribution.* The amount of this contribution may be
13 applied to any product offered by the California Cooperative Health
14 Insurance Purchasing Program except the Cal-CHIPP Healthy
15 Families plan.

16 (d) An employer may pay all, or a portion of, the premium
17 payment required of its employees enrolled in Cal-CHIPP.

18 12699.204.1. The board shall limit enrollment in the Cal-CHIPP
19 Healthy Families plan to individuals who are eligible under Sections
20 14005.301 and 14005.305 of the Welfare and Institutions Code
21 and to individuals eligible under Section 12699.211.01 with a
22 family income greater than 100 percent of the federal poverty level.

23 12699.206. (a) The board shall negotiate with Medi-Cal
24 managed care plans to obtain affordable coverage for eligible
25 enrollees. Nothing in this subdivision shall limit the ability of the
26 board to contract with other licensed health care service plans or
27 health insurers holding a valid certificate of authority.

28 (b) The board, in consultation with the State Department of
29 Health Care Services, shall take all reasonable steps necessary to
30 maximize federal funding and support federal claiming in the
31 administration of the purchasing pool created pursuant to this part.

32 12699.206.1. (a) To provide prescription drug coverage for
33 Cal-CHIPP enrollees, the board may take any of the following
34 actions:

35 (1) Contract directly with health care service plans or health
36 insurers for prescription drug coverage as a component of a health
37 care service plan contract or a health insurance policy.

38 (2) Procure products directly through the prescription drug
39 purchasing program established pursuant to Chapter 12

1 (commencing with Section 14977) of Part 5.5 of Division 3 of
2 Title 2 of the Government Code.

3 (b) The board may engage in any of the activities described in
4 subdivision (a), or in any cost-effective combination of those
5 activities.

6 (c) If the board enters into a prescription drug purchasing
7 arrangement pursuant to paragraph (2) of subdivision (a), the board
8 may allow any of the following entities to participate in that
9 arrangement:

10 (1) Any state, district, county, city, municipal, or other public
11 agency or governmental entity.

12 (2) A board of trustees or plan administrator responsible for
13 providing or delivering health care coverage pursuant to a collective
14 bargaining agreement, memorandum of understanding, or other
15 similar agreement with a labor organization. Nothing in this section
16 shall modify, alter or amend the fiduciary duties of these entities
17 under applicable federal and state laws.

18 (d) Notwithstanding this section, any licensed health care service
19 plan shall be subject to all statutory and regulatory requirements
20 applicable to coverage for prescription drugs under the Knox-Keene
21 Health Care Service Plan Act of 1975.

22 12699.206.2. (a) All information, whether written or oral,
23 concerning an applicant to Cal-CHIPP, an enrollee in Cal-CHIPP,
24 or a household member of the applicant or enrollee, created or
25 maintained by a public officer or agency in connection with the
26 administration of this part shall be confidential and shall not be
27 open to examination other than for purposes directly connected
28 with the administration of this part. "Purposes directly connected
29 with the administration of this part" includes all activities and
30 responsibilities in which the board or the State Department of
31 Health Care Services and their agents, officers, trustees, employees,
32 consultants, and contractors engage to conduct program operations.

33 (b) Information subject to the provisions of this section includes,
34 but is not limited to, names and addresses, medical services
35 provided to an enrollee, social and economic conditions or
36 circumstances, agency evaluation of personal information, and
37 medical data, such as diagnosis and health history.

38 (c) Nothing in this section shall be construed to prohibit the
39 disclosure of information about applicants and enrollees, or their
40 household members, if express written authorization for the

1 disclosure has been provided by the person to whom the
2 information pertains or, if that person is a minor, authorization has
3 been provided by the minor’s parent or other adult with legal
4 custody of the minor.

5 (d) The use and disclosure of information concerning an
6 applicant or enrollee in the program who is a beneficiary in the
7 Medi-Cal program or an applicant to the Medi-Cal program shall
8 be strictly limited to the circumstances described in Section
9 14100.2 of the Welfare and Institutions Code.

10 (e) Except as provided in subdivision (d), nothing in this part
11 shall prohibit the disclosure of protected health information as
12 provided in Section 164.152 of Title 45 of the Code of Federal
13 Regulations.

14 12699.207. (a) Notwithstanding any other provision of law,
15 the board shall not be subject to licensure or regulation by the
16 Department of Insurance or the Department of Managed Health
17 Care.

18 (b) Participating health, dental, and vision care plans that
19 contract with the board shall be regulated by either the Department
20 of Insurance or the Department of Managed Health Care and shall
21 be licensed and in good standing with their respective licensing
22 agency. In their application to Cal-CHIPP and upon request by the
23 board, the participating health, dental, and vision care plans shall
24 provide assurance of their licensure and standing with the
25 appropriate licensing agency.

26 12699.208. The board shall collect and disseminate, as
27 appropriate and to the extent possible, information on the quality
28 of participating health, dental, and vision care plans and each plan’s
29 cost-effectiveness to assist enrollees in selecting a plan.

30 12699.208.01. Participating carriers may contract with agents
31 or brokers to provide marketing and servicing of health benefits
32 coverage offered through the program. Any commissions set and
33 paid pursuant to this section shall be determined by the
34 participating carrier and the agent or broker.

35 12699.208.02. (a) In addition to the duties specified in Section
36 12699.202, the board shall coordinate with the Franchise Tax
37 Board in the administration of the tax credit established by Section
38 17052.30 of the Revenue and Taxation Code.

39 (b) The board shall, on behalf of an enrollee who is a qualified
40 taxpayer as defined in Section 17052.30 of the Revenue and

1 Taxation Code, pay any premium credit advance that may be
2 authorized to that qualified taxpayer or to the participating health
3 plan in which the enrollee receives coverage for himself or herself
4 or for his or her dependents.

5 (c) A participating health plan providing coverage pursuant to
6 this part shall credit payments under this section against the
7 enrollee's premium.

8 (d) In administering this section the board shall:

9 (1) Exchange information, including the total amount of
10 qualified premiums paid by each taxpayer during the calendar
11 year, total amount of any premium credit advances paid to or on
12 behalf of each taxpayer during the calendar year, the specific
13 average premium amounts by age category for a plan from
14 coverage choice category 3 offered pursuant to subdivision (c) of
15 Section 12699.203, and other necessary or appropriate information,
16 with the Franchise Tax Board solely for the purpose of the
17 administration and enforcement of Section 17052.30 of the
18 Revenue and Taxation Code and any premium credit advance that
19 may be authorized.

20 (2) Administer any premium credit advance that may be
21 authorized.

22 (3) Establish the form and manner by which a qualified taxpayer
23 applies for any premium credit advance that may be authorized,
24 which shall include the provision of the applicant's social security
25 number or other taxpayer identification number.

26 (4) Provide each qualified taxpayer an annual statement
27 regarding premiums paid and any premium credit advances that
28 may be authorized to be paid to the qualified taxpayer or to a
29 participating plan on behalf of the qualified taxpayer.

30 (e) For purposes of this section, "premium credit advance"
31 means any premium credit advance that may be authorized in
32 accordance with the intent reflected in Section 17052.31 of the
33 Revenue and Taxation Code.

34 12699.209. The board shall consult and coordinate with the
35 State Department of Health Care Services in seeking federal
36 financial support for Cal-CHIPP Healthy Families coverage
37 provided pursuant to this part. To the extent that the state obtains
38 federal financial support for that subsidized coverage, the coverage
39 shall be subject to the terms, conditions, and duration of any
40 applicable state plan amendment or waiver. To the extent required

1 to obtain federal financial support, the board shall apply citizenship,
2 immigration, and identity documentation standards required in
3 Title XIX of the federal Social Security Act.

4 12699.210. The provisions of Section 12693.54 shall apply to
5 a contract entered into pursuant to this part.

6
7 CHAPTER 3. ELIGIBILITY
8

9 12699.211. To be eligible to enroll in Cal-CHIPP, an individual
10 must be a resident of the state pursuant to Section 244 of the
11 Government Code or physically present in the state, having entered
12 the state with an employment commitment or to obtain
13 employment, whether or not employed at the time of application
14 to Cal-CHIPP or after enrollment in Cal-CHIPP. In addition, to
15 be eligible to enroll in Cal-CHIPP, an individual must meet one
16 of the following requirements:

17 (a) Be an employee or a dependent of an employee of an
18 employer who elected to pay *the full contribution* into the
19 California Health Trust Fund.

20 (b) Be an individual eligible for coverage pursuant to Section
21 14005.301 or 14005.305 of the Welfare and Institutions Code.

22 (c) Be an individual described in Section 12699.211.01.

23 (d) Be an employee or his or her dependent paying the full cost
24 of health care coverage through an employee tax savings plan
25 established pursuant to Section 4801 of the Unemployment
26 Insurance Code, where the employer designates Cal-CHIPP in the
27 cafeteria plan.

28 (e) Be eligible for a state tax credit made available pursuant to
29 Section 17052.30 of the Revenue and Taxation Code.

30 12699.211.01. (a) Eligibility for coverage under this part shall
31 be available through enrollment in the Cal-CHIPP Healthy Families
32 plan to a population composed of individuals who meet all of the
33 following requirements:

34 (1) Is a resident of the state pursuant to Section 244 of the
35 Government Code or is physically present in the state, having
36 entered the state with an employment commitment or to obtain
37 employment, whether or not employed at the time of application
38 to the program.

39 (2) Is a citizen or national of the United States or a qualified
40 alien without regard to date of entry.

1 (3) Is 19 years of age or older and is ineligible for Medicare
2 Parts A and B.

3 (4) Has family income, less applicable deductions, greater than
4 100 percent of the federal poverty level but less than or equal to
5 250 percent of the federal poverty level.

6 (5) Is ineligible for the Medi-Cal program.

7 (6) Is not offered employer-sponsored health care coverage or
8 ~~where there is no financial contribution toward the premium by~~
9 ~~the employer on behalf of the employee~~ *the individual is enrolled*
10 *in or eligible for health expenditures that may be credited against*
11 *any required employer health care contribution.*

12 (b) Implementation of this section is contingent on the
13 establishment of a county share of cost.

14 12699.211.02. (a) The following program decisions may be
15 appealed to the board:

16 (1) A decision that an individual is not qualified to participate
17 or continue to participate in the program.

18 (2) A decision that an individual is not eligible for enrollment
19 or continuing enrollment in the program.

20 (3) A decision as to the effective date of coverage.

21 (b) An applicant or subscriber who appeals one of the decisions
22 listed in subdivision (a) shall be accorded an opportunity for an
23 administrative hearing. The hearing shall be conducted, insofar as
24 practicable, pursuant to Chapter 5 (commencing with Section
25 11500) of Part 1 of Division 3 of the Government Code.

26 (c) To the extent required by law, the board shall implement
27 this section consistent with applicable federal law.

28 12699.211.03. The board may, through regulations adopted
29 pursuant to Chapter 3.5 (commencing with Section 11340) of Part
30 1 of Division 3 of Title 2 of the Government Code, allow
31 individuals who enrolled in coverage under this chapter and who
32 would be otherwise ineligible to continue that coverage, to be
33 eligible for extended coverage for a period of time established by
34 the board, not to exceed 18 months from the date of ineligibility,
35 if the individual pays the entire cost for the coverage. Coverage
36 extension policies under this section may not increase coverage
37 costs for other pool participants. The board may differentiate or
38 delimit eligibility or conditions for such continuation coverage, as
39 well as the rating factors used, depending on the basis of initial
40 eligibility and the coverage options available to that person.

1 12699.211.04. The State Department of Health Care Services,
2 in consultation with the board, shall convene a stakeholders group
3 to develop an outreach and enrollment process for the purchasing
4 pool program that is cost effective and coordinated with the
5 Medi-Cal and Healthy Families programs, in order to ensure
6 seamless access to coverage through these programs for eligible
7 Californians. The process and procedures shall be subject to
8 implementation through future legislative action. The involved
9 stakeholders shall include, but not be limited to, legislative staff,
10 counties, consumer organizations, labor organizations, and others
11 as appropriate. In developing the procedures, items to be considered
12 shall include, but not be limited to, simplicity and ease of
13 enrollment, current enrollment practices, quality, accuracy,
14 competence, customer service, cost-effectiveness, need for
15 automation, problem resolution, timeliness, and ensuring that
16 federal requirements regarding screening and enrollment processes
17 and procedures are met. Implementation of the process shall be
18 contingent on funding being appropriated for this purpose.

19
20
21

CHAPTER 4. FISCAL

22 12699.212. (a) The California Health Trust Fund is hereby
23 created in the State Treasury for the purpose of the Health Care
24 Security and Cost Reduction Act. Any moneys in the fund that are
25 unexpended or unencumbered at the end of a fiscal year, may be
26 carried forward to the next succeeding fiscal year.

27 (b) The board shall establish a prudent reserve in the fund.

28 (c) Notwithstanding Section 16305.7 of the Government Code,
29 all interest earned on the moneys that have been deposited into the
30 fund shall be retained in the fund.

31 12699.216. The board, subject to federal approval and an
32 appropriation therefor, shall pay the nonfederal share of cost from
33 the fund for individuals eligible under that federal approval.
34 Revenues in the fund shall be used, upon appropriation, to the
35 extent allowable under federal law, as state matching funds for
36 receipt of federal funds.

37 12699.217. This part shall become operative on January 1,
38 2009. The board shall provide health coverage pursuant to this
39 part on and after July 1, 2010.

1 SEC. 54. Part 6.7 (commencing with Section 12739.50) is
2 added to Division 2 of the Insurance Code, to read:

3

4 PART 6.7. MINIMUM CREDITABLE COVERAGE

5

6 12739.50. (a) On or before March 1, 2009, the Managed Risk
7 Medical Insurance Board shall establish, by regulation, the
8 definition of minimum creditable coverage for purposes of
9 compliance with the requirement in Section 8899.50 of the
10 Government Code. On or before March 1, 2009, the board shall
11 also establish, by regulation, the standards for minimum creditable
12 coverage that at a minimum apply to the individual health insurance
13 market. The standards set by the board pursuant to this section
14 shall ensure that minimum creditable coverage at least includes
15 coverage for physician, hospital, and preventive services and is at
16 a minimum inclusive of existing coverage requirements under law.

17 (b) The board shall consult with the Director of the Department
18 of Managed Health Care and the Insurance Commissioner in
19 developing the standards for minimum creditable coverage.

20 (c) In establishing the standards for minimum creditable
21 coverage, including the scope of services, enrollee and dependent
22 deductible, copayment requirements, and coverage of services
23 outside the deductible, the board shall consider all of the following:

24 (1) The degree to which minimum creditable coverage protects
25 individuals subject to the requirement of Section 8899.50 of the
26 Government Code and health purchasers from catastrophic medical
27 costs.

28 (2) The extent to which cost sharing, including any deductible,
29 coinsurance, or copayment requirements, would deter an enrollee
30 or his or her dependents from obtaining appropriate and timely
31 care, including consideration of coverage for prevention services
32 that would not be subject to any deductible. The board shall
33 consider the importance of encouraging periodic health evaluations
34 and the use of services that have been shown to be effective in
35 ~~detecting or preventing serious illness~~, *preventing, or managing*
36 *serious illness and chronic conditions*.

37 (3) The affordability of the minimum policy for individuals who
38 are subject to the requirements of Section 8899.50 of the
39 Government Code, taking into account deductibles, coinsurance,
40 copayments, and total out-of-pocket costs, and the extent to which

1 the resulting premium cost would prevent an individual from
2 obtaining coverage at a reasonable price.

3 (4) The extent to which and under what circumstances benefits
4 offered or provided by a bona fide church, sect, denomination, or
5 organization whose principles include healing entirely by prayer
6 or spiritual means may be included in or qualify as meeting the
7 requirement to maintain minimum creditable coverage under
8 Section 8899.50 of the Government Code.

9 12739.501. (a) A person or family who has an income at or
10 below 250 percent of the federal poverty level shall be exempt
11 from the requirements established in Section 8899.50 of the
12 Government Code if the person's or family's share of the premium
13 for 8899.50 minimum creditable coverage exceeds 5 percent of
14 his or her family's income.

15 (b) In addition to the exemption pursuant to subdivision (a), the
16 board shall adopt regulations by January 1, 2010, to establish *and*
17 *review* affordability and hardship standards for purposes of the
18 requirements in Section 8899.50 of the Government Code. In
19 developing these standards, the board shall consider all of the
20 following:

21 (1) The availability of public coverage, subsidies, and tax credits
22 for low-income individuals and families.

23 (2) Total out-of-pocket costs associated with minimum
24 creditable coverage, including premiums, copays, coinsurance,
25 and deductibles.

26 (3) The percentage or amount of a taxpayer's adjusted gross
27 income that the individual would be required to contribute toward
28 premiums for health care.

29 (4) The percentage of family income that persons insured across
30 all health care markets currently spend on their health care
31 premiums, copays, coinsurance, and deductibles.

32 (5) The percentage of insured persons who meet or exceed their
33 deductibles.

34 (6) The impact of the premium amount on the ability of an
35 individual or family to afford other necessities of life, including,
36 but not limited to, expenses for housing, utilities, food, clothing,
37 child care, transportation, education, and taxes. It is the intent of
38 the Legislature that an individual's contributions toward health
39 care coverage premiums not interfere with his or her ability to pay
40 for basic necessities of life.

1 (7) The effect of the exemption criteria on premium levels for
2 all health care coverage purchasers.

3 (8) Specific circumstances and conditions that could make it a
4 temporary hardship for an individual to be required to purchase
5 minimum creditable coverage, such as significant increases in
6 basic living expenses because of unexpected changes in family
7 circumstances, expenses or living arrangements or hardship that
8 results from a fire, flood, natural disaster or other unexpected
9 natural or human-caused event causing substantial household or
10 personal damage.

11 (c) The board shall develop a process for considering requests
12 for exemptions for affordability and hardship and for granting
13 those exemptions if the board determines that the purchase or
14 continuation of minimum creditable coverage would create an
15 undue hardship on an individual or family. The board shall consider
16 the offering of both temporary and continuing hardship exemptions
17 and shall establish the timelines and the process whereby an
18 individual and family must obtain coverage after the expiration of
19 a temporary exemption and the board shall establish an individual’s
20 rights and responsibilities related to obtaining that coverage.
21 Individuals who are granted an exemption by the board shall not
22 be subject to the requirements of Section 8899.50 of the
23 Government Code for the period prescribed by the board.

24 (d) The board shall track and identify, to the extent feasible, the
25 number of individuals who are exempted from the mandate to
26 maintain minimum creditable coverage in Section 8899.50 of the
27 Government Code as a result of the exemptions developed by the
28 board, including the specific types and categories of those
29 exemptions, and report the information to the Legislature and to
30 the Director of the Department of Managed Health Care to be used
31 in establishing the reinsurance mechanisms in Section 1399.844
32 of the Health and Safety Code.

33 12739.51. (a) On or before January 1, 2010, the Managed Risk
34 Medical Insurance Board shall establish and maintain an active
35 statewide education and awareness program to inform all California
36 residents of their obligation under Section 8899.50 of the
37 Government Code, including informing them of the options
38 available to obtain affordable coverage through public programs,
39 the state purchasing pool, and commercial coverage.

1 (b) The board, in consultation with the State Department of
2 Health Care Services, shall identify and implement methods and
3 strategies to establish multiple entry points and opportunities for
4 enrollment in public or private coverage, as appropriate, for
5 individuals subject to Section 8899.50 of the Government Code.
6 The board shall work with state and local agencies, health care
7 providers, health plans, employers, consumer groups, community
8 organizations, and other appropriate stakeholders to establish
9 point-of-service methods to facilitate enrollment of individuals
10 who do not have or maintain minimum creditable coverage as
11 required under Section 8899.50 of the Government Code. The
12 board shall identify and implement in state-administered health
13 care programs, to the greatest extent practicable and permissible
14 under federal law, best practices for streamlined eligibility and
15 enrollment.

16 (c) The board shall establish methods by which individuals who
17 have not obtained health care coverage shall be informed of the
18 method available to obtain affordable coverage through public
19 programs, the program established pursuant to Part 6.45
20 (commencing with Section 12699.201) of Division 2 of the
21 Insurance Code, and commercial coverage. The board shall also
22 establish methods to ensure that uninsured individuals obtain the
23 minimum creditable coverage. The board shall pay the cost of
24 health care coverage on behalf of a previously uninsured individual
25 who is enrolled in minimum creditable coverage by the board after
26 being uninsured for at least 62 days, and the board shall establish
27 methods by which funds advanced for coverage may be recouped
28 by the state from individuals for whom coverage is purchased. The
29 board may enter into an agreement with the Franchise Tax Board
30 to use the Franchise Tax Board's civil authority and procedures
31 in compliance with notice and other due process requirements
32 imposed by law to collect funds owed to the state that were
33 advanced to individuals pursuant to this subdivision.

34 (d) To the extent possible, activities undertaken pursuant to
35 subdivision (c) shall be based on existing reporting processes
36 employed throughout the state to report on the employment and
37 tax status of individuals and other existing mechanisms. Relevant
38 state agencies shall cooperate with the board and other responsible
39 entities in undertaking these activities and implementing this
40 section.

1 (e) The board may enter into agreements with other agencies
 2 or departments to perform the activities required under this section.
 3 Prior to entering into any agreements, the board shall report to the
 4 Legislature on the activities to be undertaken pursuant to
 5 subdivision (c). The report shall include the method by which
 6 individuals with and without coverage are identified, the method
 7 by which persons are to be given notice of the availability of
 8 coverage and the timeframe to enroll, the actions that will be taken
 9 to enroll uninsured persons, and the actions that will be taken if
 10 persons do not enroll in minimum creditable coverage. The board
 11 shall submit the required report by March 15, 2010.

12 (f) The board shall adopt regulations, as appropriate, to
 13 implement this section.

14 (g) Implementation of *any of the provisions of* this section shall
 15 be contingent on the appropriation of funds for the purposes of
 16 this section in the annual Budget Act or another statute.

17 SEC. 55. Section 12886 is added to the Insurance Code, to
 18 read:

19 12886. It shall constitute an unfair labor practice contrary to
 20 public policy, and enforceable under Section 95 of the Labor Code,
 21 for an employer to refer an individual employee or employee's
 22 dependent to the program established pursuant to Part 6.45
 23 (commencing with Section 12699.201), or to arrange for an
 24 individual employee or employee's dependent to apply to that
 25 program, for the purpose of separating that employee or employee's
 26 dependent from group health coverage provided in connection
 27 with the employee's employment. An employer who pays the
 28 premium for the employee in the program established pursuant to
 29 Part 6.45 (commencing with Section 12699.201) shall not, on the
 30 basis of that action, be deemed to be in violation of this section.

31 SEC. 56. Section 12887 is added to the Insurance Code, to
 32 read:

33 12887. It shall constitute an unfair labor practice contrary to
 34 public policy and enforceable under Section 95 of the Labor Code
 35 for an employer to change the employee-employer share-of-cost
 36 ratio based upon the employee's wage base or job classification
 37 or to make any modification of coverage for employees and
 38 employees' dependents in order that the employees or employees'
 39 dependents enroll in the program established pursuant to Part 6.45
 40 (commencing with Section 12699.201).

1 SEC. 57. Section 96.8 is added to the Labor Code, to read:

2 96.8. (a) Notwithstanding any other provision in this chapter,
3 an employer may provide health coverage that includes a Healthy
4 Action Incentives and Rewards Program that meets the
5 requirements of Section 1367.38 of the Health and Safety Code,
6 or Section 10123.56 of the Insurance Code, to the employer's
7 employees.

8 (b) A Healthy Action Incentives and Rewards Program offered
9 pursuant to this section may include, but need not be limited to,
10 monetary incentives and health coverage premium cost reductions
11 for employees for nonsmokers and smoking cessation.

12 SEC. 57.1. Section 17052.30 is added to the Revenue and
13 Taxation Code, to read:

14 17052.30. (a) (1) For each taxable year beginning on or after
15 January 1, 2010, and before January 1, 2015, there shall be allowed
16 as a credit against the "net tax," as defined in Section 17039, an
17 amount equal to those qualified health care plan premium costs
18 that are in excess of 5.5 percent of a qualified taxpayer's adjusted
19 gross income for the taxable year.

20 (2) The amount of credit otherwise allowed under paragraph
21 (1) shall be reduced by 1 percent for every 2 percent by which the
22 qualified taxpayer's adjusted gross income exceeds 300 percent
23 of the applicable federal poverty level.

24 (3) No credit shall be allowed under this section to a qualified
25 taxpayer with adjusted gross income in excess of 400 percent of
26 the applicable federal poverty level.

27 (4) (A) In the case of any taxpayer who is not a qualified
28 taxpayer for the entire taxable year, the allowable credit under
29 paragraph (1) shall be computed by first dividing the total adjusted
30 gross income of the qualified taxpayer by 12, and then multiplying
31 that amount by the number of months during the taxable year that
32 the taxpayer is a qualified taxpayer.

33 (B) Paragraphs (2) and (3) shall apply to any taxpayer described
34 in subparagraph (A), without the adjustment required under
35 subparagraph (A).

36 (C) The maximum amount of credit for any month computed
37 pursuant to this paragraph shall not exceed the maximum monthly
38 credit amount prescribed in paragraph (5).

39 (5) (A) The maximum annual and monthly allowable credit
40 amounts for health care premiums shall be as follows:

1 Maximum Annual Credit Amount

2 Age	3 Single	4 Subscriber & Spouse	5 Subscriber & Child	6 Subscriber & Children	7 Family
4 19-29	\$0	\$665	\$629	\$816	\$1,500
5 30-34	\$135	\$1,457	\$962	\$1,410	\$2,634
6 35-39	\$441	\$2,069	\$1,034	\$1,608	\$3,093
7 40-44	\$909	\$2,600	\$1,088	\$1,725	\$3,687
8 45-49	\$1,071	\$3,338	\$1,268	\$1,914	\$4,263
9 50-54	\$1,755	\$4,679	\$1,988	\$2,607	\$5,370
10 55-59	\$2,646	\$6,335	\$3,104	\$3,444	\$6,954
11 60-64	\$3,762	\$8,090	\$4,112	\$4,740	\$8,772

13 Children only	14 <1	15 1-18	16 1 child	17 2 children	18 3+ children
13 Children only	14 <1	15 1-18	16 1 child	17 2 children	18 3+ children
	\$0	\$0	\$0	\$0	\$264

18 Maximum Monthly Credit Amount

19 Age	20 Single	21 Subscriber & Spouse	22 Subscriber & Child	23 Subscriber & Children	24 Family
21 19-29	\$0	\$55	\$52	\$68	\$125
22 30-34	\$11	\$121	\$80	\$118	\$220
23 35-39	\$37	\$172	\$86	\$134	\$258
24 40-44	\$76	\$217	\$91	\$144	\$307
25 45-49	\$89	\$278	\$106	\$160	\$355
26 50-54	\$146	\$390	\$166	\$217	\$448
27 55-59	\$221	\$528	\$259	\$287	\$580
28 60-64	\$314	\$674	\$343	\$395	\$731

30 Children only	31 <1	32 1-18	33 1 child	34 2 children	35 3+ children
30 Children only	31 <1	32 1-18	33 1 child	34 2 children	35 3+ children
	\$0	\$0	\$0	\$0	\$22

36 (B) For each taxable year beginning on or after January 1, 2010,
 37 the Franchise Tax Board shall recompute the maximum annual
 38 and monthly credit amounts reflected in subparagraph (A) to reflect
 39 the change in the California Consumer Price Index, U Medical
 40 Care, from July 1, 2007, to June 30 of the calendar year

1 immediately preceding the beginning of the taxable year for which
2 the recomputation is to be made.

3 (C) The Department of Industrial Relations shall transmit
4 annually to the Franchise Tax Board, no later than August 1 of the
5 current calendar year, the percentage change in the California
6 Consumer Price Index, U Medical Care, from July 1 of the prior
7 calendar year to June 30 of the current calendar year.

8 (D) Notwithstanding any other provision of this section or any
9 premium credit advance that may be authorized in accordance with
10 the intent reflected in Section 17052.31, the maximum allowable
11 amount of either of those credits shall not exceed the applicable
12 maximum credit amounts identified in subparagraph (A), as
13 recomputed in accordance with subparagraph (B).

14 (b) For purposes of this section:

15 (1) “Adjusted gross income” means adjusted gross income as
16 computed for purposes of Section 17072.

17 (2) (A) “Federal poverty level” has the same meaning as poverty
18 guidelines updated periodically in the Federal Register by the
19 United States Department of Health and Human Services pursuant
20 to Section 9902(2) of Title 42 of the United States Code.

21 (B) For purposes of determining the applicable federal poverty
22 level, family size equals the sum of the number of individuals,
23 including a taxpayer, spouse, and each dependent reported on the
24 return for the taxable year.

25 (3) “MRMIB” means the Managed Risk Medical Insurance
26 Board in its capacity in administering the program established
27 pursuant to Article 6.45 (commencing with Section 12699.201)
28 of Division 2 of the Insurance Code.

29 (4) “Premium for a plan from coverage choice category 3”
30 means the monthly average cost, as determined and updated
31 annually by the MRMIB, of a health care service plan contract or
32 health insurance policy from coverage choice category 3 of the
33 products offered by MRMIB pursuant to subdivision (c) of Section
34 12699.203 of the Insurance Code for the applicable age category.
35 *This health care service plan contract or health insurance policy*
36 *shall be one that covers prescription drugs, physician visits, and*
37 *preventive services, including the services to manage chronic*
38 *conditions, outside of any deductible. The MRMIB shall provide*
39 *to the Franchise Tax Board the specific premium amounts for this*

1 plan for purposes of determining the qualified health care plan
2 premium cost, as described in paragraph (6) of this subdivision.

3 (5) “Qualified health care plan” means any health plan, other
4 than a Cal-CHIP Healthy Families Plan, purchased through the
5 MRMIB pursuant to subdivision (c) of Section 12699.203 of the
6 Insurance Code that provides health care coverage to satisfy the
7 requirements established pursuant to Section 8899.50 of the
8 Government Code for a qualified taxpayer, his or her spouse, or
9 their dependents, including any health insurance policy or health
10 care service plan contract.

11 (6) “Qualified health care plan premium costs” means amounts
12 paid by the qualified taxpayer during the taxable year for a qualified
13 health care plan that are equal to 75 percent of the lesser of either
14 of the following:

15 (A) The qualified premiums paid during the taxable year by the
16 qualified taxpayer.

17 (B) The monthly premium for a plan from coverage choice
18 category 3 multiplied by the number of months during the taxable
19 year that the taxpayer is a qualified taxpayer.

20 (7) “Qualified premiums” means the amounts paid by a qualified
21 taxpayer to purchase a qualified health care plan through the
22 MRMIB for coverage for the period during which the taxpayer is
23 a qualified taxpayer. Any premium credit advance, as may be
24 authorized in accordance with the intent reflected in Section
25 17052.31, used by the MRMIB to pay all or a portion of premiums
26 payable of a qualified taxpayer, shall be considered “qualified
27 premiums.”

28 (8) (A) “Qualified taxpayer” means any taxpayer whose
29 adjusted gross income for the taxable year is at least 250 percent,
30 but not in excess of 400 percent, of the applicable federal poverty
31 level for the calendar year that begins in the taxable year for which
32 the credit is claimed.

33 (B) (i) Except as provided in clause (ii), any taxpayer who is
34 eligible to receive coverage under a group health plan that is offered
35 through the taxpayer’s employment or through the employment
36 of the taxpayer’s spouse for which the employer pays any portion
37 of the cost *or where the individual is enrolled in or eligible for*
38 *health expenditures that may be credited against any required*
39 *employer health care contribution* is not a qualified taxpayer under

1 subparagraph (A) during any period that the taxpayer is eligible
2 to receive coverage as described in this subparagraph.

3 (ii) A taxpayer shall be considered a qualified taxpayer if the
4 group health plan described in clause (i) does not provide coverage
5 with respect to one or more dependents of the taxpayer, but only
6 to the extent of the qualified health care plan premium costs paid
7 by the taxpayer with respect to those dependents.

8 (C) Any taxpayer who is eligible to receive coverage under the
9 Cal-CHIPP Healthy Families Plan pursuant to Part 6.45
10 (commencing with Section 12699.201) of Division 2 of the
11 Insurance Code or the Medi-Cal program established pursuant to
12 Chapter 7 (commencing with Section 14000) of Part 3 of Division
13 9 of the Welfare and Institutions Code is not a qualified taxpayer
14 under subparagraph (A) during any period that the taxpayer is
15 eligible to receive coverage as described in this subparagraph.

16 (9) “Dependent” means dependent as defined in Section 8899.50
17 of the Government Code.

18 (c) In the case of a married couple, the credit allowed by this
19 section shall be claimed on a joint return.

20 (d) In the case where the credit allowed under this section
21 exceeds the “net tax,” the excess shall be credited against other
22 amounts due, if any, by the qualified taxpayer and the balance, if
23 any, shall, upon appropriation by the Legislature, be refunded to
24 the qualified taxpayer.

25 (e) The Franchise Tax Board, in consultation with the MRMIB,
26 may prescribe those regulations as may be necessary or appropriate
27 to carry out the purposes of this section.

28 (f) (1) ~~All amounts deposited into~~ *Appropriate amounts in the*
29 California Health Trust Fund established pursuant to Section
30 12699.212 of the Insurance Code shall, upon appropriation by the
31 Legislature, be transferred as follows:

32 (A) To the MRMIB for purposes of advancing the refundable
33 credit for the purchase of health care plan premiums.

34 (B) To the Franchise Tax Board for the purpose of recovering
35 the amounts expended from the Tax Relief and Refund Account
36 for amounts claimed as credits against tax liability and amounts
37 in excess of tax liability as authorized under subdivision (d).

38 (2) The Franchise Tax Board shall notify the MRMIB of the
39 aggregate amount of tax credits allowed pursuant to subdivision
40 (a) in each fiscal quarter.

1 (g) (1) No credit shall be allowed under this section for any
2 taxable year in the disallowance period.

3 (2) For purposes of this section, the “disallowance period” is
4 either of the following:

5 (A) The period of two taxable years after the most recent taxable
6 year for which there was a final determination that the taxpayer’s
7 claim of credit under this section was due to fraud.

8 (B) The period of two taxable years after the most recent taxable
9 year for which there was a final determination that the taxpayer’s
10 claim of credit under this section was due to reckless or intentional
11 disregard of rules and regulations, but not due to fraud.

12 (h) This section shall remain in effect only until December 31,
13 2015, and as of that date is repealed.

14 SEC. 57.2. Section 17052.31 is added to the Revenue and
15 Taxation Code, to read:

16 17052.31. It is the intent of the Legislature to enact legislation
17 to authorize the credit under Section 17052.30 to be advanceable.

18 SEC. 57.3. Section 17052.32 is added to the Revenue and
19 Taxation Code, to read:

20 17052.32. It is the intent of the Legislature to enact legislation
21 to authorize a health care coverage credit for persons who are
22 between the ages of 50 and 64, inclusive, and are not qualified
23 taxpayers as defined in paragraph (8) of subdivision (b) of Section
24 17052.30, to the extent fiscal resources are available, not to exceed
25 fifty million dollars (\$50,000,000) annually, subject to an
26 appropriation.

27 SEC. 57.4. Section 19167 of the Revenue and Taxation Code
28 is amended to read:

29 19167. A penalty shall be imposed under this section for any
30 of the following:

31 (a) In accordance with Section 6695(a) of the Internal Revenue
32 Code, for failure to furnish a copy of the return to the taxpayer, as
33 required by Section 18625.

34 (b) In accordance with Section 6695(c) of the Internal Revenue
35 Code, for failure to furnish an identifying number, as required by
36 Section 18624.

37 (c) In accordance with Section 6695(d) of the Internal Revenue
38 Code, for failure to retain a copy or list, as required by Section
39 18625 or for failure to retain an electronic filing declaration, as
40 required by Section 18621.5.

1 (d) Failure to register as a tax preparer with the California Tax
2 Education Council, as required by Section 22253 of the Business
3 and Professions Code, unless it is shown that the failure was due
4 to reasonable cause and not due to willful neglect.

5 (1) The amount of the penalty under this subdivision for the
6 first failure to register is two thousand five hundred dollars
7 (\$2,500). This penalty shall be waived if proof of registration is
8 provided to the Franchise Tax Board within 90 days from the date
9 notice of the penalty is mailed to the tax preparer.

10 (2) The amount of the penalty under this subdivision for a failure
11 to register, other than the first failure to register, is five thousand
12 dollars (\$5,000).

13 (e) The Franchise Tax Board shall not impose the penalties
14 authorized by subdivision (d) until either one of the following has
15 occurred:

16 (1) Commencing January 1, 2006, and continuing each year
17 thereafter, there is an appropriation in the Franchise Tax Board's
18 annual budget to fund the costs associated with the penalty
19 authorized by subdivision (d).

20 (2) (A) An agreement has been executed between the California
21 Tax Education Council and the Franchise Tax Board that provides
22 that an amount equal to all first year costs associated with the
23 penalty authorized by subdivision (d) shall be received by the
24 Franchise Tax Board. For purposes of this subparagraph, first year
25 costs include, but are not limited to, costs associated with the
26 development of processes or systems changes, if necessary, and
27 labor.

28 (B) An agreement has been executed between the California
29 Tax Education Council and the Franchise Tax Board that provides
30 that the annual costs incurred by the Franchise Tax Board
31 associated with the penalty authorized by subdivision (d) shall be
32 reimbursed by the California Tax Education Council to the
33 Franchise Tax Board.

34 (C) Pursuant to the agreement described in subparagraph (A),
35 the Franchise Tax Board has received an amount equal to the first
36 year costs described in that subparagraph.

37 (f) (1) In accordance with Section 6695(g) of the Internal
38 Revenue Code, as modified by paragraphs (2) and (3), for failure
39 to be diligent in determining eligibility for the refundable credit
40 authorized under Section 17052.30.

1 (2) The amount of the penalty imposed under this subdivision
2 shall be one thousand dollars (\$1,000) for each failure.

3 (3) For purposes of the penalty imposed under this subdivision,
4 the due diligence requirements imposed by the Secretary of the
5 Treasury under Section 6695(g) of the Internal Revenue Code, and
6 any regulations promulgated thereunder, shall be modified by the
7 Franchise Tax Board through instructions or notices.

8 SEC. 57.5. Section 19528.5 is added to the Revenue and
9 Taxation Code, to read:

10 19528.5. (a) Notwithstanding any other law, the Franchise
11 Tax Board may establish an agreement with the Managed Risk
12 Medical Insurance Board under which the MRMIB provides a
13 report to the Franchise Tax Board, at a time and in the manner
14 prescribed by the Franchise Tax Board, the following information
15 with respect to every individual that purchased a health care plan
16 through the MRMIB in the calendar year:

- 17 (1) Name.
- 18 (2) Address or addresses of record.
- 19 (3) Social security number or other taxpayer identification
20 number.
- 21 (4) Total amount of health care plan premiums paid in the
22 calendar year.
- 23 (5) Total amount of premium credit advances, as may be
24 authorized in accordance with the intent reflected in Section
25 17052.31, for purchase of premiums in the calendar year.

26 (b) The reports required under this section shall be transmitted
27 through a secure electronic process in a form and manner as shall
28 be jointly determined by the MRMIB and the Franchise Tax Board.

29 (c) Information provided to the Franchise Tax Board by the
30 MRMIB shall be used only for tax administration purposes and
31 shall be deemed to be return information within the meaning of
32 Section 19549.

33 SEC. 57.6. Section 19553.5 is added to the Revenue and
34 Taxation Code, to read:

35 19553.5. (a) Subject to the limitations of this section and
36 federal law, including Section 6103 of the Internal Revenue Code,
37 the Franchise Tax Board may provide the Managed Risk Medical
38 Insurance Board with information obtained from a state income
39 tax return for purposes of verifying income, filing status, and
40 number of dependents of an applicant for health care plan coverage

1 obtained through the MRMIB. Use of the information provided
2 under this section shall be limited to determining eligibility for
3 premium credit advances, as may be authorized in accordance with
4 the intent reflected in Section 17052.31.

5 (b) Neither the MRMIB nor any officer, employee, or agent, or
6 former officer, employee, or agent, of the MRMIB may disclose
7 or use any information obtained from the Franchise Tax Board
8 pursuant to this section except for the purposes of administering
9 health care plan coverage for taxpayers.

10 SEC. 57.7. Section 19611 of the Revenue and Taxation Code
11 is amended to read:

12 19611. (a) The Tax Relief and Refund Account is hereby
13 created in the General Fund. Notwithstanding Section 13340 of
14 the Government Code, all moneys in the Tax Relief and Refund
15 Account are hereby continuously appropriated, without regard to
16 fiscal year, to the Franchise Tax Board for purposes of making all
17 payments as provided in this section.

18 (b) Notwithstanding any other law, all payments required to be
19 made to taxpayers or other persons from the Personal Income Tax
20 Fund shall be paid from the Tax Relief and Refund Account.

21 (c) The Controller shall transfer, as needed, to the Tax Relief
22 and Refund Account:

23 (1) From the unexpended balance of the annual Budget Act
24 appropriation for Item 9100-101-001, Schedule 80-Renter's Tax
25 Relief, an amount determined by the Franchise Tax Board to be
26 equivalent to the total amount of renters' assistance credits and
27 refunds allowed under Section 17053.5.

28 (A) If there is no unexpended balance of the appropriation, as
29 provided for in paragraph (1), the Controller shall transfer sufficient
30 moneys from the Personal Income Tax Fund to make the renters'
31 assistance credits and refunds until there is an unexpended balance.

32 (B) Subsequent to there being no unexpended balance of the
33 appropriation, as provided for in paragraph (1), and there being a
34 transfer of moneys from the Personal Income Tax Fund to make
35 the renters' assistance credits and refunds, reimbursement shall be
36 made from the unexpended balance of the appropriation as provided
37 for in paragraph (1) to the Personal Income Tax Fund. However,
38 if no such appropriation is subsequently made, reimbursement
39 shall be made from the General Fund.

1 (2) From the disability fund, the amount transferable to the
2 General Fund pursuant to subdivision (a) of Section 1176.5 of the
3 Unemployment Insurance Code.

4 (3) From the Personal Income Tax Fund, such additional
5 amounts as determined by the Franchise Tax Board to be necessary
6 to make the payments required under this section.

7 (4) Upon appropriation by the Legislature, the following
8 transfers shall be made:

9 (A) From the unexpended balance of the California Health Trust
10 Fund established pursuant to Section 12699.215 of the Insurance
11 Code, an amount determined by the Franchise Tax Board to be
12 equivalent to the total amount of health care premium credits
13 allowed under Section 17052.30.

14 (B) If there is no unexpended balance of the California Health
15 Trust Fund, as provided for in this paragraph, the Controller shall,
16 upon appropriation by the Legislature, transfer sufficient moneys
17 from the Personal Income Tax Fund for credits allowed under
18 Section 17052.30.

19 (C) Subsequent to there being no unexpended balance of the
20 California Health Trust Fund, as provided for in this paragraph,
21 and there being a transfer of moneys from the Personal Income
22 Tax Fund to allow the health care premium credits, reimbursement
23 shall, upon appropriation by the Legislature, be made from the
24 unexpended balance of the California Health Trust Fund, as
25 provided for in this paragraph, to the Personal Income Tax Fund.
26 However, if no such appropriation is subsequently made,
27 reimbursement shall, upon appropriation by the Legislature, be
28 made from the General Fund.

29 SEC. 58. Section 301.1 is added to the Unemployment
30 Insurance Code, to read:

31 301.1. (a) The Employment Development Department shall
32 establish data collection and reporting methods and requirements,
33 compatible with existing forms and filings that employers submit
34 to the department, to collect and report information related to
35 employer health expenditures on behalf of their employees.

36 (b) The Employment Development Department shall report on
37 the data collected pursuant to subdivision (a) to the Managed Risk
38 Medical Insurance Board and to the Legislature on an annual basis
39 commencing April 1, 2011.

1 (c) The Employment Development Department may adopt
2 regulations to implement this section as needed.

3 SEC. 58.5. Section 1120 is added to the Unemployment
4 Insurance Code, to read:

5 1120. Any employer who fails to establish or maintain a
6 cafeteria plan as required by Section 4801 shall pay a penalty of
7 one hundred dollars (\$100) per employee for the failure to establish
8 or maintain a cafeteria plan without good cause, or five hundred
9 dollars (\$500) per employee if the failure to establish or maintain
10 a cafeteria plan is willful.

11 SEC. 59. Division 1.2 (commencing with Section 4800) is
12 added to the Unemployment Insurance Code, to read:

13
14 DIVISION 1.2. HEALTH CARE TAX SAVINGS PLAN

15
16 4800. This division shall be known and may be cited as the
17 Health Care Tax Savings Plan.

18 4801. (a) Each employer of one or more employees in this
19 state shall, beginning January 1, 2010, adopt and maintain a
20 cafeteria plan, within the meaning of Section 125 of the Internal
21 Revenue Code, to allow all employees to pay premiums for health
22 care coverage to the extent amounts for that coverage are
23 excludable from the gross income of the employee under Section
24 106 of the Internal Revenue Code.

25 (b) The establishment or maintenance of a cafeteria plan shall
26 neither be inconsistent with Section 125 of Title 26 of the United
27 States Code, nor require any employer to take any action that would
28 violate Section 125 of Title 26 of the United States Code.

29 (c) For the purposes of this division, the following definitions
30 apply:

31 (1) "Employee" means an employee as defined in Article 1.5
32 (commencing with Section 621) of Chapter 3 of Part 1 of Division
33 1.

34 (2) "Employer" means an employer as defined in Article 3
35 (commencing with Section 675) of Chapter 3 of Part 1 of Division
36 1, except as described in subdivision (a) of Section 683 and in
37 subdivision (a) of Section 685.

38 (3) "Employing unit" means an "employing unit" as defined in
39 Section 135.

1 (4) “Employment” means employment as defined in Article 1
 2 (commencing with Section 601) of Chapter 3 of Part 1 of Division
 3 1. “Employment” does not include services excluded under Section
 4 632, subdivision (c) of Section 634.5, and Sections 640, 641, 643,
 5 644, and 644.5.

6 (d) The department shall promulgate rules and regulations to
 7 implement the provisions of this division.

8 SEC. 60. Section 12306.1 of the Welfare and Institutions Code
 9 is amended to read:

10 12306.1. (a) When any increase in provider wages or benefits
 11 is negotiated or agreed to by a public authority or nonprofit
 12 consortium under Section 12301.6, then the county shall use
 13 county-only funds to fund both the county share and the state share,
 14 including employment taxes, of any increase in the cost of the
 15 program, unless otherwise provided for in the annual Budget Act
 16 or appropriated by statute. No increase in wages or benefits
 17 negotiated or agreed to pursuant to this section shall take effect
 18 unless and until, prior to its implementation, the department has
 19 obtained the approval of the State Department of Health Services
 20 for the increase pursuant to a determination that it is consistent
 21 with federal law and to ensure federal financial participation for
 22 the services under Title XIX of the federal Social Security Act,
 23 and unless and until all of the following conditions have been met:

24 (1) Each county has provided the department with
 25 documentation of the approval of the county board of supervisors
 26 of the proposed public authority or nonprofit consortium rate,
 27 including wages and related expenditures. The documentation shall
 28 be received by the department before the department and the State
 29 Department of Health Services may approve the increase.

30 (2) Each county has met department guidelines and regulatory
 31 requirements as a condition of receiving state participation in the
 32 rate.

33 (b) Any rate approved pursuant to subdivision (a) shall take
 34 effect commencing on the first day of the month subsequent to the
 35 month in which final approval is received from the department.
 36 The department may grant approval on a conditional basis, subject
 37 to the availability of funding.

38 (c) The state shall pay 65 percent, and each county shall pay 35
 39 percent, of the nonfederal share of wage and benefit increases
 40 negotiated by a public authority or nonprofit consortium pursuant

1 to Section 12301.6 and associated employment taxes, only in
2 accordance with subdivisions (d) to (f), inclusive.

3 (d) (1) The state shall participate as provided in subdivision (c)
4 in wages up to seven dollars and fifty cents (\$7.50) per hour and
5 individual health benefits up to sixty cents (\$0.60) per hour for all
6 public authority or nonprofit consortium providers. This paragraph
7 shall be operative for the 2000–01 fiscal year and each year
8 thereafter unless otherwise provided in paragraphs (2), (3), (4),
9 and (5), and without regard to when the wage and benefit increase
10 becomes effective.

11 (2) The state shall participate as provided in subdivision (c) in
12 a total of wages and individual health benefits up to nine dollars
13 and ten cents (\$9.10) per hour, if wages have reached at least seven
14 dollars and fifty cents (\$7.50) per hour. Counties shall determine,
15 pursuant to the collective bargaining process provided for in
16 subdivision (c) of Section 12301.6, what portion of the nine dollars
17 and ten cents (\$9.10) per hour shall be used to fund wage increases
18 above seven dollars and fifty cents (\$7.50) per hour or individual
19 health benefit increases, or both. This paragraph shall be operative
20 for the 2001–02 fiscal year and each fiscal year thereafter, unless
21 otherwise provided in paragraphs (3), (4), and (5).

22 (3) The state shall participate as provided in subdivision (c) in
23 a total of wages and individual health benefits up to ten dollars
24 and ten cents (\$10.10) per hour, if wages have reached at least
25 seven dollars and fifty cents (\$7.50) per hour. Counties shall
26 determine, pursuant to the collective bargaining process provided
27 for in subdivision (c) of Section 12301.6, what portion of the ten
28 dollars and ten cents (\$10.10) per hour shall be used to fund wage
29 increases above seven dollars and fifty cents (\$7.50) per hour or
30 individual health benefit increases, or both. This paragraph shall
31 be operative commencing with the next state fiscal year for which
32 the May Revision forecast of General Fund revenue, excluding
33 transfers, exceeds by at least 5 percent, the most current estimate
34 of revenue, excluding transfers, for the year in which paragraph
35 (2) became operative.

36 (4) The state shall participate as provided in subdivision (c) in
37 a total of wages and individual health benefits up to eleven dollars
38 and ten cents (\$11.10) per hour, if wages have reached at least
39 seven dollars and fifty cents (\$7.50) per hour. Counties shall
40 determine, pursuant to the collective bargaining process provided

1 for in subdivision (c) of Section 12301.6, what portion of the eleven
2 dollars and ten cents (\$11.10) per hour shall be used to fund wage
3 increases or individual health benefits, or both. This paragraph
4 shall be operative commencing with the next state fiscal year for
5 which the May Revision forecast of General Fund revenue,
6 excluding transfers, exceeds by at least 5 percent, the most current
7 estimate of revenues, excluding transfers, for the year in which
8 paragraph (3) became operative.

9 (5) (A) The state shall participate as provided in subdivision
10 (c) in a total cost of wages and individual health benefits up to
11 twelve dollars and ten cents (\$12.10) per hour, if wages have
12 reached at least seven dollars and fifty cents (\$7.50) per hour.
13 Counties shall determine, pursuant to the collective bargaining
14 process provided for in subdivision (c) of Section 12301.6, what
15 portion of the twelve dollars and ten cents (\$12.10) per hour shall
16 be used to fund wage increases above seven dollars and fifty cents
17 (\$7.50) per hour or individual health benefit increases, or both.

18 (B) In addition to participating in a total cost of wages and
19 individual health benefits up to twelve dollars and ten cents
20 (\$12.10) per hour as provided for in subparagraph (A), and in
21 addition to the amount up to sixty cents (\$0.60) per hour provided
22 for in paragraph (1), the state shall participate in an additional
23 twenty-five cents (\$0.25) per hour so long as the additional funds
24 under this subparagraph are used to increase funding for individual
25 health benefits. This subparagraph shall become inoperative when
26 subparagraph (C) goes into effect.

27 (C) In addition to participating in a total cost of wages and
28 individual health benefits up to twelve dollars and ten cents
29 (\$12.10) per hour as provided for in subparagraph (A), and in
30 addition to the amount up to sixty cents (\$0.60) per hour provided
31 for in paragraph (1), the state shall participate in an additional fifty
32 cents (\$0.50) per hour so long as the additional funds under this
33 subparagraph are used to increase funding for individual health
34 benefits. This subparagraph shall be operative commencing with
35 the next state fiscal year for which the May Revision forecast of
36 General Fund revenue, excluding transfers, exceeds by at least 5
37 percent, the most current estimate of revenue, excluding transfers,
38 for the year in which subparagraph (B) became operative. This
39 subparagraph shall become inoperative when subparagraph (D)
40 goes into effect.

1 (D) In addition to participating in a total cost of wages and
2 individual health benefits up to twelve dollars and ten cents
3 (\$12.10) per hour as provided for in subparagraph (A), and in
4 addition to the amount up to sixty cents (\$0.60) per hour provided
5 for in paragraph (1), the state shall participate in an additional
6 seventy-five cents (\$0.75) per hour so long as the additional funds
7 under this subparagraph are used to increase funding for individual
8 health benefits. This subparagraph shall be operative commencing
9 with the next state fiscal year for which the May Revision forecast
10 of General Fund revenue, excluding transfers, exceeds by at least
11 5 percent, the most current estimate of revenue, excluding transfers,
12 for the year in which subparagraph (C) became operative.

13 (e) (1) On or before May 14 immediately prior to the fiscal
14 year for which state participation is provided under paragraphs (2)
15 to (5), inclusive, of subdivision (d), the Director of Finance shall
16 certify to the Governor, the appropriate committees of the
17 Legislature, and the department that the condition for each
18 subdivision to become operative has been met.

19 (2) For purposes of certifications under paragraph (1), the
20 General Fund revenue forecast, excluding transfers, that is used
21 for the relevant fiscal year shall be calculated in a manner that is
22 consistent with the definition of General Fund revenues, excluding
23 transfers, that was used by the Department of Finance in the
24 2000–01 Governor’s Budget revenue forecast as reflected on
25 Schedule 8 of the Governor’s Budget.

26 (f) Any increase in overall state participation in wage and benefit
27 increases under paragraphs (2) to (5), inclusive, of subdivision (d),
28 shall be limited to a wage and benefit increase of one dollar (\$1)
29 per hour with respect to any fiscal year. With respect to actual
30 changes in specific wages and health benefits negotiated through
31 the collective bargaining process, the state shall participate in the
32 costs, as approved in subdivision (c), up to the maximum levels
33 as provided under paragraphs (2) to (5), inclusive, of subdivision
34 (d).

35 (g) In any county with employee representation, the employee
36 representative may elect to provide health benefits through a trust
37 fund and the public authority or nonprofit consortium shall agree
38 to those terms that term.

39 (h) The recipient of in-home supportive services shall not be
40 deemed the employer for purposes of any employer fee that may

1 be established to finance the expansion of health care coverage to
2 provide coverage to all Californians. *Any such employer fee*
3 *requirement shall be met in the same manner as provided in Section*
4 *12302.2.*

5 SEC. 61. Section 14005.30 of the Welfare and Institutions
6 Code is amended to read:

7 14005.30. (a) (1) To the extent that federal financial
8 participation is available, Medi-Cal benefits under this chapter
9 shall be provided to individuals eligible for services under Section
10 1396u-1 of Title 42 of the United States Code, including any
11 options under Section 1396u-1(b)(2)(C) made available to and
12 exercised by the state.

13 (2) The department shall exercise its option under Section
14 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
15 less restrictive income and resource eligibility standards and
16 methodologies to the extent necessary to allow all recipients of
17 benefits under Chapter 2 (commencing with Section 11200) to be
18 eligible for Medi-Cal under paragraph (1).

19 (3) To the extent federal financial participation is available, the
20 department shall exercise its option under Section 1396u-1(b)(2)(C)
21 of Title 42 of the United States Code authorizing the state to
22 disregard all changes in income or assets of a beneficiary until the
23 next annual redetermination under Section 14012. The department
24 shall implement this paragraph only if, and to the extent that the
25 State Child Health Insurance Program waiver described in Section
26 12693.755 of the Insurance Code extending Healthy Families
27 Program eligibility to parents and certain other adults is approved
28 and implemented.

29 (b) (1) To the extent that federal financial participation is
30 available, the department shall exercise its option under Section
31 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
32 to expand eligibility for Medi-Cal under subdivision (a) by
33 establishing the amount of countable resources individuals or
34 families are allowed to retain at the same amount medically needy
35 individuals and families are allowed to retain, except that a family
36 of one shall be allowed to retain countable resources in the amount
37 of three thousand dollars (\$3,000). This paragraph shall not be
38 operative during implementation of paragraph (2).

39 (2) To the extent that federal financial participation is available,
40 the department shall exercise its option under Section

1 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
2 to simplify eligibility for Medi-Cal under subdivision (a) by
3 exempting all resources for applicants and recipients, commencing
4 July 1, 2010.

5 (c) To the extent federal financial participation is available, the
6 department shall, commencing March 1, 2000, adopt an income
7 disregard for applicants equal to the difference between the income
8 standard under the program adopted pursuant to Section 1931(b)
9 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and
10 the amount equal to 100 percent of the federal poverty level
11 applicable to the size of the family. A recipient shall be entitled
12 to the same disregard, but only to the extent it is more beneficial
13 than, and is substituted for, the earned income disregard available
14 to recipients.

15 (d) For purposes of calculating income under this section during
16 any calendar year, increases in social security benefit payments
17 under Title II of the federal Social Security Act (42 U.S.C. Sec.
18 401 and following) arising from cost-of-living adjustments shall
19 be disregarded commencing in the month that these social security
20 benefit payments are increased by the cost-of-living adjustment
21 through the month before the month in which a change in the
22 federal poverty level requires the department to modify the income
23 disregard pursuant to subdivision (c) and in which new income
24 limits for the program established by this section are adopted by
25 the department.

26 (e) Notwithstanding Chapter 3.5 (commencing with Section
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
28 the department shall implement, without taking regulatory action,
29 subdivisions (a) and (b) of this section by means of an all-county
30 letter or similar instruction. Thereafter, the department shall adopt
31 regulations in accordance with the requirements of Chapter 3.5
32 (commencing with Section 11340) of Part 1 of Division 3 of Title
33 2 of the Government Code. Beginning six months after the effective
34 date of this section, the department shall provide a status report to
35 the Legislature on a semiannual basis until regulations have been
36 adopted.

37 SEC. 62. Section 14005.301 is added to the Welfare and
38 Institutions Code, to read:

39 14005.301. (a) The department shall provide benefits pursuant
40 to Section 14005.306 to a population composed of parents and

1 other caretaker relatives who meet all of the following
2 requirements:

3 (1) Net family income is at or below 250 percent of the federal
4 poverty level.

5 (2) The individual is not otherwise eligible for full-scope
6 benefits under Section 14005.30 but would be eligible for these
7 benefits if family income were at or below 100 percent of the
8 federal poverty level.

9 (3) The individual is a citizen, national, or qualified alien without
10 regard to date of entry.

11 (b) The eligibility determination under this section shall not
12 include an asset test.

13 (c) The department shall implement this section by means of a
14 state plan amendment under Section 1902(a)(10)(A)(ii)(I) of the
15 federal Social Security Act (Title 42 U.S.C. Sec.
16 1396a(a)(10)(A)(ii)(I)), or by any other state plan amendment or
17 waiver, or combination thereof, as is necessary to accomplish the
18 intent of this section.

19 (d) The department shall seek federal approval to utilize the
20 same premiums and copayments for the population described in
21 this section as are applied to the population eligible for the
22 Cal-CHIP Healthy Families plan established pursuant to Section
23 12699.204 of the Insurance Code.

24 (e) To the extent necessary to implement this section and Section
25 14005.305, the department shall seek federal approval to waive
26 the deprivation requirement or to modify the definition of
27 unemployed parent provided in Section 14008.85.

28 (f) This section shall be implemented only if and to the extent
29 that federal approval to provide benchmark benefits in a manner
30 consistent with Section 14005.306 has been obtained.

31 (g) The income test for eligibility determinations under this
32 section shall be the same test used for the federal poverty level
33 programs, but shall not include any income disregards available
34 under those programs.

35 (h) This section shall become operative on July 1, 2010, or on
36 the date that the authority under Section 12739.51 is implemented,
37 whichever is later.

38 SEC. 63. Section 14005.305 is added to the Welfare and
39 Institutions Code, to read:

1 14005.305. (a) The department shall provide benefits to a
2 population composed of individuals who are either 19 or 20 years
3 of age and who meet all of the following requirements:

4 (1) Net family income is at or below 250 percent of the federal
5 poverty level.

6 (2) The individual is not otherwise eligible for full-scope
7 benefits in one of the federal poverty level programs for children,
8 but would be eligible for those benefits if he or she were under 19
9 years of age with income at or below 100 percent of the federal
10 poverty level.

11 (3) The individual is a citizen, national, or qualified alien without
12 regard to date of entry.

13 (b) The eligibility determination under this section shall not
14 include an asset test.

15 (c) The department shall implement this section by means of a
16 state plan amendment under Section 1902(a)(10)(A)(ii)(I) of the
17 federal Social Security Act (Title 42 U.S.C. Sec.
18 1396a(a)(10)(A)(ii)(I)), or by any other state plan amendment or
19 waiver, or combination thereof, as is necessary to accomplish the
20 intent of this section.

21 (d) The department shall seek federal approval to utilize the
22 same premiums and copayments for the population to whom this
23 section applies as are applied to the population established pursuant
24 to Section 12699.211.01 of the Insurance Code.

25 (e) This section shall be implemented only if, and to the extent
26 that federal approval has been obtained to provide benchmark
27 benefits for individuals made eligible under this section with net
28 income over 100 percent of the federal poverty level in a manner
29 consistent with Section 14005.306.

30 (f) The income methodology for eligibility determinations under
31 this section shall be the methodology used for the federal poverty
32 level programs, but shall not include any income disregards
33 available under those programs.

34 (g) This section shall become operative on July 1, 2010, or on
35 the date that Section 12739.51 of the Insurance Code is
36 implemented, whichever is later, but only to the extent federal
37 financial participation is available.

38 SEC. 64. Section 14005.306 is added to the Welfare and
39 Institutions Code, to read:

1 14005.306. (a) Subject to the limitations provided in
2 subdivisions (b) and (c), a Medi-Cal beneficiary with a net family
3 income above 100 percent of the federal poverty level whose
4 eligibility is based on Section 14005.301 or Section 14005.305
5 and who is otherwise eligible for full-scope benefits, shall receive
6 his or her benefits by means of a benchmark package pursuant to
7 Section 1937 of the federal Social Security Act. This package shall
8 be the Cal-CHIPP Healthy Families benefit package established
9 for the program established pursuant to Part 6.45 (commencing
10 with Section 12699.201) of Division 2 of the Insurance Code.

11 (b) To the extent required by federal law, the categories of
12 beneficiaries listed in Section 1937(a)(2)(B) of the federal Social
13 Security Act (Title 42 U.S.C. Sec. 1396u-7(a)(2)(B)), are exempt
14 from mandatory enrollment in the benchmark package described
15 in subdivision (a).

16 (c) The department, with the concurrence of the Managed Risk
17 Medical Insurance Board, may identify groups of otherwise exempt
18 individuals that will be allowed a choice, at the beneficiary's
19 option, to participate in a benchmark package.

20 (d) The department, with concurrence of the Managed Risk
21 Medical Insurance Board, may exempt other groups or categories
22 of beneficiaries from the requirements provided in subdivision (a).

23 (e) To the extent federal approval is obtained, the appeals
24 process for issues relating to receipt of benefits through the
25 benchmark package shall be the process prescribed by the Managed
26 Risk Medical Insurance Board for the program established pursuant
27 to Part 6.45 (commencing with Section 12699.201) of Division 2
28 of the Insurance Code.

29 (f) This section shall be implemented only if and to the extent
30 that federal financial participation is available and all necessary
31 federal approvals have been obtained.

32 (g) The department shall accomplish the intent of this section
33 by means of a state plan amendment or by a waiver. If this section
34 is implemented in whole or in part by means of a state plan
35 amendment, all applicable federal requirements not otherwise
36 waived, including, but not limited to, requirements related to cost
37 sharing, shall apply.

38 SEC. 65. Section 14005.310 is added to the Welfare and
39 Institutions Code, to read:

1 14005.310. The department shall seek federal approval to utilize
2 an interval of one year in determining the cost amounts specified
3 in Section 12699.204 of the Insurance Code for persons receiving
4 benchmark benefits pursuant to Sections 14005.301 and 14005.305.

5 SEC. 66. Section 14005.311 is added to the Welfare and
6 Institutions Code, to read:

7 14005.311. (a) The department and the Managed Risk Medical
8 Insurance Board shall enter into an interagency agreement under
9 which the board shall have authority and responsibility for
10 administering benchmark benefits under Sections 14005.301 and
11 14005.305 and for prescribing all rules and procedures necessary
12 for administering these benefits subject to the single state agency
13 oversight responsibilities of the department and consistent with
14 the process developed pursuant to Section 12699.211.04 of the
15 Insurance Code.

16 (b) This section shall be implemented only to the extent that
17 federal financial participation is not jeopardized.

18 SEC. 67. Section 14005.331 is added to the Welfare and
19 Institutions Code, to read:

20 14005.331. (a) An individual under the age of 19 years who
21 would be eligible for full-scope Medi-Cal benefits without a share
22 of cost, if not for his or her immigration status, shall be eligible
23 for full-scope Medi-Cal services under this section.

24 (b) To establish that the individual meets the immigration
25 requirements under this section, the parent or caretaker relative
26 shall sign under penalty of perjury an attestation that the individual
27 is not described in any of the categories enumerated on the
28 attestation for which federal financial participation for full-scope
29 services is available.

30 (c) In implementing this section, the department shall consult
31 with stakeholders, including, but not limited to, consumer
32 advocates and counties.

33 (d) Nothing in this section shall be construed to limit a child's
34 access to Medi-Cal or Healthy Families eligibility under existing
35 law.

36 (e) Implementation of this section is contingent upon an
37 appropriation for the purposes of this section in the annual Budget
38 Act or another statute.

39 (f) This section shall become operative on July 1, 2009.

1 SEC. 68. Section 14005.333 is added to the Welfare and
2 Institutions Code, to read:

3 14005.333. (a) The department shall design and implement a
4 program to provide the benefits described in subdivision (d) to the
5 population described in subdivision (c).

6 (b) The department shall seek to maximize the availability of
7 federal funding for this section under the terms of any existing
8 waiver, through amendment of any existing waiver, or by means
9 of a new waiver, or any combination thereof.

10 (c) The population eligible to receive benefits under this section
11 shall consist of all residents 21 years of age or older who meet all
12 of the following requirements.

13 (1) Their family income is at or below 100 percent of the federal
14 poverty level.

15 (2) They are not otherwise eligible for the Medi-Cal program.

16 (3) They would be eligible for full-scope Medi-Cal without a
17 share of cost if they had a categorical linkage.

18 (4) They are citizens, nationals, or qualified aliens without
19 regard to date of entry.

20 (5) They are not offered employer-sponsored health care
21 coverage or ~~where there is no financial contribution toward the~~
22 ~~premium by the employer on behalf of the employee~~ *the individual*
23 *is enrolled in or eligible for health expenditures that may be*
24 *credited against any required employer health care contribution.*

25 (d) Benefits available under this section shall consist of a benefit
26 package that is designed by the department and is equivalent to
27 the Cal-CHIPP Healthy Families plan coverage defined in
28 subdivision (g) of Section 12699.201 that is made available in the
29 purchasing pool established pursuant to Part 6.45 (commencing
30 with Section 12699.201) of Division 2 of the Insurance Code. To
31 the extent that specific services are excluded from the subsidized
32 package, these services are not required to be provided under this
33 section to the population described under subdivision (c). These
34 excluded services shall include, but are not limited to, long-term
35 care services, nursing home care, personal care services, in-home
36 supportive services, and home- and community-based or other
37 waiver services.

38 (e) In determining eligibility for benefits under this section, the
39 department shall use the application requirements and the income
40 methodology of the federal poverty level programs for pregnant

1 women and children, including the income deductions and
2 exemptions applicable under those programs, but shall not include
3 any income disregards available under those programs.

4 (f) Notwithstanding Section 14007.2 or any other provision of
5 law, this section creates no right or entitlement for any individual
6 to receive any service including any emergency service, unless
7 that individual has been determined to meet all of the eligibility
8 requirements in subdivision (c) and the documentation and
9 verification requirements in subdivision (g).

10 (g) In order for an otherwise eligible individual to be eligible
11 for, or to receive, any service, including, but not limited to, any
12 emergency service under this section, the individual shall be
13 required to meet all of the minimum federal requirements necessary
14 for federal claiming by furnishing all necessary information and
15 providing all necessary documentation.

16 (h) Except to the extent required by the terms of any applicable
17 federal waiver, federal Medicaid rights, including the right to
18 retroactive eligibility, do not apply to persons or services under
19 this section.

20 (i) Nothing in this section is intended to affect or modify the
21 availability of the eligibility category described in Section 14052
22 or the application process, documentation requirements,
23 methodology, or benefits available pursuant to that section.

24 (j) Implementation of this section is contingent on the
25 establishment of a county share of cost.

26 (k) This section shall become operative on July 1, 2010, or on
27 the date that the authority under Section 12739.51 of the Insurance
28 Code is implemented, whichever is later.

29 SEC. 69. Section 14011.16 of the Welfare and Institutions
30 Code is amended to read:

31 14011.16. (a) Commencing August 1, 2003, the department
32 shall implement a requirement for beneficiaries to file semiannual
33 status reports as part of the department's procedures to ensure that
34 beneficiaries make timely and accurate reports of any change in
35 circumstance that may affect their eligibility. The department shall
36 develop a simplified form to be used for this purpose. The
37 department shall explore the feasibility of using a form that allows
38 a beneficiary who has not had any changes to so indicate by
39 checking a box and signing and returning the form.

1 (b) Beneficiaries who have been granted continuous eligibility
2 under Section 14005.25 shall not be required to submit semiannual
3 status reports. To the extent federal financial participation is
4 available, all children under 19 years of age shall be exempt from
5 the requirement to submit semiannual status reports.

6 (c) Beneficiaries whose eligibility is based on a determination
7 of disability or on their status as aged or blind shall be exempt
8 from the semiannual status report requirement described in
9 subdivision (a). The department may exempt other groups from
10 the semiannual status report requirement as necessary for simplicity
11 of administration.

12 (d) When a beneficiary has completed, signed, and filed a
13 semiannual status report that indicated a change in circumstance,
14 eligibility shall be redetermined.

15 (e) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department shall implement this section by means of all-county
18 letters or similar instructions without taking regulatory action.
19 Thereafter, the department shall adopt regulations in accordance
20 with the requirements of Chapter 3.5 (commencing with Section
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

22 (f) This section shall be implemented only if and to the extent
23 federal financial participation is available.

24 (g) This section shall become inoperative upon implementation
25 of Section 14011.16.1 and shall remain inoperative for as long as
26 that section continues to be implemented.

27 SEC. 70. Section 14011.16.1 is added to the Welfare and
28 Institutions Code, to read:

29 14011.16.1. (a) Commencing July 1, 2010, the department
30 shall implement a requirement for any beneficiary who is not
31 required to make premium payments to file a semiannual address
32 verification report. The department shall develop a simplified form
33 to be used for this purpose so that a beneficiary who has not had
34 a change of address can so indicate by checking a box and returning
35 the form.

36 (b) When a beneficiary who is required to complete and return
37 the form described in subdivision (a) fails to do so, the county
38 shall follow up by attempting to contact the individual using the
39 last known phone number or numbers. If the attempted phone
40 contact fails to resolve the issue by providing confirmation of the

1 current address, the county shall search available files to determine
2 if an alternate or new address has been used by the beneficiary and
3 shall send a form to that address that is required to be returned. In
4 the absence of a new or alternate address, a form shall be sent to
5 the last known address. If the form is not returned, or if it is
6 returned under circumstances indicating that the individual no
7 longer resides at the address last provided by the individual and
8 no forwarding address is provided, eligibility shall be terminated
9 for loss of contact.

10 (c) Whenever Medi-Cal eligibility is terminated based on a loss
11 of contact as described in this section, the entity responsible for
12 redeterminations of eligibility for the affected beneficiary shall
13 document the facts causing the eligibility termination in the
14 beneficiary's file. Following this written certification, a notice of
15 action specifying that Medi-Cal eligibility was terminated based
16 on loss of contact shall be sent to the beneficiary.

17 (d) A beneficiary whose eligibility is based on a determination
18 of disability or on his or her status as aged or blind shall be exempt
19 from the requirements of subdivision (a).

20 (e) Children under 19 years of age and pregnant women shall
21 be exempt from the requirements of this section.

22 (f) The department may exempt categories or groups of
23 individuals from the requirement to file an address verification as
24 necessary for simplicity of administration.

25 (g) This section shall be implemented only if and to the extent
26 that its implementation does not jeopardize federal financial
27 participation.

28 SEC. 71. Section 14074.5 is added to the Welfare and
29 Institutions Code, to read:

30 14074.5. The department shall seek to maximize the availability
31 of federal funding for the costs of providing Cal-CHIPP Healthy
32 Families coverage to non-Medi-Cal beneficiaries through the
33 program established pursuant to Part 6.45 (commencing with
34 Section 12699.201) of Division 2 of the Insurance Code.

35 SEC. 72. Section 14081.6 is added to the Welfare and
36 Institutions Code, to read:

37 14081.6. If Article 5.21 (commencing with Section 14167.1)
38 or Article 5.22 (commencing with Section 14167.31), or both,
39 become inoperative, hospitals shall be paid for services rendered
40 to Medi-Cal beneficiaries at the rates that were in effect on June

1 30, 2010, including the rates paid pursuant to the provisions of
2 this article.

3 SEC. 73. Section 14092.5 is added to the Welfare and
4 Institutions Code, to read:

5 14092.5. (a) (1) The director shall establish a local coverage
6 option program to provide Medi-Cal coverage for low-income
7 adults eligible pursuant to Section 14005.333. The program shall
8 meet the requirements of this section.

9 (2) For a four-year period beginning with the first month of
10 operation of a local coverage option program in a county under
11 this section, the local coverage option program shall be the
12 exclusive Medi-Cal coverage available for the individuals who
13 reside in the county and who are eligible Medi-Cal beneficiaries
14 under Section 14005.333.

15 (b) Local coverage option programs shall only be implemented
16 in counties that operate designated public hospitals where the
17 county elects to operate a local coverage option program and the
18 department approves the county's application. Counties operating
19 a local coverage option shall provide coverage for those eligible
20 individuals described in Section 14005.333 who reside in the
21 county.

22 (1) All covered services shall be provided by designated public
23 hospitals, their affiliated public providers, and primary care clinics
24 licensed under subdivision (a) of Section 1204 of the Health and
25 Safety Code, except with respect to those medically necessary
26 services that are not available or accessible through these providers.
27 Local coverage option programs shall contract with primary care
28 clinics licensed under subdivision (a) of Section 1204 of the Health
29 and Safety Code in the county and provide reimbursement for
30 covered services to the extent and as required by federal law. Each
31 enrollee shall be assigned a medical home at a public provider
32 affiliated with a public hospital or at a primary care clinic licensed
33 under subdivision (a) of Section 1204 of the Health and Safety
34 Code. Local coverage option programs shall contract with
35 additional providers, including safety net providers such as
36 disproportionate share hospitals, for services to enrollees as
37 necessary to comply with the Knox-Keene Health Care Service
38 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
39 of Division 2 of the Health and Safety Code) or other provisions
40 of law.

1 (2) Counties may only provide coverage in a local coverage
2 option through a health care service plan licensed under the
3 Knox-Keene Health Care Service Plan Act of 1975. The local
4 coverage option may include any one of the following:

5 (A) Direct operation through a county-operated licensed health
6 care service plan.

7 (B) Operation through a local initiative, created pursuant to
8 Section 14087.31, 14087.35, or 14087.38 that is licensed as a
9 health care service plan.

10 (C) Operation through a county organized health system
11 described in Section 14087.51 or 14087.54 that is licensed as a
12 health care service plan.

13 (3) The department shall issue a request for applications from
14 applicable counties and shall approve applications based on the
15 criteria set forth in subdivisions (g) and (h).

16 (4) The department shall enter into contracts with those counties
17 that have had their applications approved by the department.

18 (5) In implementing this section, the department may enter into
19 contracts for the provision of essential administrative and other
20 services.

21 (6) (A) If a county elects to provide coverage through a local
22 initiative or county organized health system, the director shall
23 contract with, and make the payments required under this section
24 to, the designated local initiative or county organized health system
25 in the county.

26 (B) An entity receiving payment under subparagraph (A),
27 including a unit or subunit of county government, shall not transfer
28 any portion of the payments received to the county or to any other
29 unit of government; provided, however, that retention of those
30 funds by the entity receiving payments under subparagraph (A)
31 for use in either the current or subsequent fiscal year is allowable.
32 Retained funds may be commingled with county funds for cash
33 management or related purposes, provided that those funds are
34 appropriately tracked and only the depositing entity is authorized
35 to expend them.

36 (c) A county may offer enrollment in its local coverage option
37 program to employers and individuals.

38 (d) In consultation with participating counties, the director shall
39 design a common identification card to be provided by the county
40 to each enrollee in a local coverage option program.

1 (e) Each county, local initiative, or county organized health
2 system that operates a local coverage option program shall be
3 entitled to periodic payments per individual who resides in the
4 county who is an eligible Medi-Cal beneficiary under Section
5 14005.333 and is enrolled in the local coverage option program.
6 Rates for those payments shall be determined by the department
7 and shall meet the requirements of Section 14301.1. During the
8 first three years of operation, the department shall offer the local
9 coverage option program the option of a contract provision that
10 sets a specified dollar threshold that, if exceeded, allows the local
11 coverage option program to share with the state the risk and gains
12 of providing coverage through a risk corridor agreement that sets
13 boundaries on profits or losses by the local coverage option
14 program above and below the specified dollar thresholds as set
15 forth in the contract between the department and the local coverage
16 option program. The risk corridor agreement shall provide that if
17 the profits or losses incurred by the local coverage option program
18 exceed an initial specified dollar threshold, the local coverage
19 option program and the state shall share in the profits or losses,
20 and that if the profits or losses incurred by the local coverage option
21 program exceed a final specified dollar threshold such profits or
22 losses shall be allocated entirely to the state. The dollar thresholds
23 and corridors for profits and losses shall be the same amount.

24 (f) All providers that provide out of network emergency services
25 to local coverage option program enrollees shall accept as payment
26 in full payments they receive from the local coverage option
27 program that comply with Section 1396u-2(b)(2)(D) of Title 42
28 of the United States Code regarding maximum payments for those
29 services.

30 (g) In consultation with the participating counties, by January
31 1, 2010, the department shall contract with an independent third
32 party to develop a local coverage option program assessment tool
33 to measure the extent to which the counties are providing quality,
34 coordinated care to eligible individuals. The local coverage option
35 program assessment tool shall be designed to evaluate the following
36 for each local coverage option program:

- 37 (1) Enrolled patient population.
- 38 (2) The use of medical services.
- 39 (3) Access and barriers to health care.

1 (4) Processes and quality of care for selected medical conditions,
2 as appropriate for the population enrolled in the program.

3 (5) Patient satisfaction.

4 (h) The following elements shall be evaluated using the local
5 coverage option program assessment tool developed under
6 subdivision (g):

7 (1) Designation of a medical home and assignment of eligible
8 individuals to a primary care provider within 60 days of enrollment.
9 For purposes of this paragraph, “medical home” means a single
10 provider or facility that maintains all of an individual’s medical
11 information. The primary care provider shall be a provider from
12 which the enrollee can access primary and preventive care, or
13 specialty care as determined appropriate by a medical professional.

14 (2) An enrollment process that includes a patient identification
15 system to demonstrate enrollment into the program.

16 (3) A screening process for individuals who may qualify for
17 enrollment into the Healthy Families Program and the Access for
18 Infants and Mothers Program prior to enrollment into the local
19 coverage option program.

20 (4) Use of a medical record system, which may include
21 electronic medical records.

22 (5) Demonstrated progress in meeting industry-accepted quality
23 monitoring processes to assess the health care outcomes of
24 individuals with chronic conditions who are enrolled in the local
25 coverage option program, including HEDIS and NCQA standards.

26 (6) Promotion of the use of preventive services and early
27 intervention.

28 (7) The ability to demonstrate how the local coverage option
29 program will promote the viability of the existing safety net health
30 care system.

31 (8) Demonstration of how the program will provide consumer
32 assistance to individuals applying to, participating in, or accessing
33 services in the local coverage option program. For purposes of this
34 paragraph, “consumer assistance” includes specific processes to
35 address consumer grievances and patient advocacy.

36 (i) After three years of operation of a local coverage option
37 program in a county, the department shall conduct a review using
38 the local coverage option program assessment tool to evaluate each
39 county’s performance against the benchmarks established under
40 subdivisions (g) and (h). If the department determines that the local

1 coverage option program in a particular county has substantially
2 met the benchmarks, the director shall extend the local coverage
3 option program in that county for an additional two years. If the
4 department concludes that a county failed to substantially meet
5 the benchmarks, the county's local coverage option program shall
6 cease to be the exclusive coverage option as provided in paragraph
7 (2) of subdivision (a). The county shall have the opportunity for
8 an administrative hearing pursuant to Section 100171 of the Health
9 and Safety Code, and for judicial review of the department's
10 determination.

11 (j) (1) After four years of operation of a local coverage option
12 program in a county, if the local coverage option program in a
13 county substantially met the benchmarks pursuant to subdivision
14 (i), Medi-Cal beneficiaries enrolled in the local coverage option
15 program shall have the ability to disenroll from the local coverage
16 option program and enroll in either the county organized health
17 system or one of the two-plan contractors in the county.

18 (2) After five years of operation of a local coverage option
19 program in a county, newly enrolled Medi-Cal beneficiaries
20 described in Section 14005.333 shall have the ability to enroll in
21 either the local coverage option program or the county organized
22 health system or one of the two-plan contractors in the county, if
23 available in the county. If the newly eligible Medi-Cal beneficiary
24 fails to select a health plan within the time specified by the director,
25 the beneficiary shall be enrolled in the local coverage program, if
26 available in the county.

27 (k) (1) Notwithstanding the Medi-Cal managed care program
28 requirements of Chapters 4 and 4.1 of Title 22 of the California
29 Code of Regulations, the director may authorize local coverage
30 option programs to offer a limited network of providers pursuant
31 to this section.

32 (2) Notwithstanding the requirements of Chapter 2.2
33 (commencing with Section 1340) of Division 2 of the Health and
34 Safety Code, and if consistent with the authority and requirements
35 of subdivision (a) of Section 1344 of the Health and Safety Code,
36 the Director of Managed Health Care may authorize local coverage
37 option programs to offer a limited network of providers pursuant
38 to this section.

1 (3) In implementing this subdivision, the directors shall find
2 the action to be in the public interest and not detrimental to the
3 protection of patients.

4 (l) The local coverage option program shall become operational
5 for services rendered on and after July 1, 2010.

6 (m) The department shall seek any federal waivers or obtain
7 approval from the Centers for Medicare and Medicaid Services of
8 a state plan amendment as necessary to allow for federal financial
9 participation under this section. This section shall only be
10 implemented if and to the extent that federal financial participation
11 is available.

12 (n) Implementation of this section is contingent on establishment
13 of a county share of cost.

14 SEC. 74. Section 14132.105 is added to the Welfare and
15 Institutions Code, to read:

16 14132.105. (a) (1) The department shall establish a Healthy
17 Action Incentives and Rewards Program to be provided as a
18 covered benefit under the Medi-Cal program.

19 (2) The benefits described in this section shall only be provided
20 under the terms and conditions determined by the department, and
21 shall meet all the requirements described in subdivision (b).

22 (b) For purposes of this section, the Healthy Action Incentives
23 and Rewards Program shall include, but need not be limited to, all
24 of the following:

25 (1) Health risk appraisals that collect information from eligible
26 beneficiaries to assess overall health status and identify risk factors,
27 including, but not limited to, smoking and smokeless tobacco use,
28 alcohol abuse, drug use, nutrition, and physical activity practices.

29 (2) A followup appointment with a licensed health care
30 professional acting within his or her scope of practice to review
31 the results of the health risk appraisal and discuss any
32 recommended actions.

33 (3) Incentives or rewards or both for eligible beneficiaries to
34 become more engaged in their health care and to make appropriate
35 choices that support good health, including obtaining health risk
36 appraisals, screening services, immunizations, or participating in
37 health lifestyle programs or practices. These programs or practices
38 may include, but need not be limited to, smoking cessation,
39 physical activity, or nutrition. Incentives may include, but need
40 not be limited to, nonmedical pharmacy products or services not

1 otherwise covered under this chapter, gym memberships, and
2 weight management programs.

3 (c) The department shall seek and obtain federal financial
4 participation and secure all federal approvals, including all required
5 state plan amendments or waivers, necessary to implement and
6 fund the services authorized under this section.

7 (d) This section shall be implemented only if and to the extent
8 that federal financial participation is available and has been
9 obtained.

10 SEC. 75. Section 14137.10 is added to the Welfare and
11 Institutions Code, to read:

12 14137.10. (a) (1) There is hereby established in the department
13 the Comprehensive Diabetes Services Program to provide
14 comprehensive diabetes prevention and management services to
15 any individual who meets the requirements set forth in paragraph
16 (2). For purposes of this subdivision, “comprehensive diabetes
17 prevention and management services” shall be defined by the
18 department based on consultation pursuant to subdivision (b).
19 Services may include, but need not be limited to, all of the
20 following:

21 (A) Screening for diabetes and prediabetes in accordance with
22 the operational screening guidelines and protocols developed for
23 the Comprehensive Diabetes Services Program utilizing the most
24 current American Diabetes Association criteria for diabetes in
25 adults.

26 (B) Providing visits by certified practitioners in accordance with
27 the operational protocols developed for the Comprehensive
28 Diabetes Service Program for eligible beneficiaries who have been
29 diagnosed with prediabetes.

30 (C) Providing culturally and linguistically appropriate lifestyle
31 coaching and self-management training for eligible adult
32 beneficiaries with prediabetes and diabetes, in accordance with
33 evidence-based interventions, to avoid unhealthy blood sugar levels
34 that contribute to the progression of diabetes and its complications.

35 (D) Conducting regular and timely laboratory evaluations, by
36 the primary care physician of the eligible beneficiary, in
37 conjunction with a program of blood sugar level self-management
38 education and training for eligible adult beneficiaries who have
39 been diagnosed with prediabetes and diabetes.

1 (2) A beneficiary is eligible for services pursuant to this section
2 if he or she is all of the following:

3 (A) Between 18 and 64 years of age.

4 (B) Not dually enrolled in the Medi-Cal program and the federal
5 Medicare program.

6 (C) Diagnosed with prediabetes or diabetes.

7 (D) Otherwise eligible for full scope of benefits under this
8 chapter but not enrolled in a Medi-Cal managed care plan.

9 (b) The department shall seek and obtain federal financial
10 participation and secure all federal approvals, including all required
11 state plan amendments or waivers, necessary to implement and
12 fund the services authorized under this section.

13 (c) For the purposes of implementation of this section, the
14 director may enter into contracts for the purposes of providing the
15 benefits offered under the Comprehensive Diabetes Services
16 Program.

17 (d) This section shall be implemented only if and to the extent
18 that federal financial participation is available and has been
19 obtained.

20 (e) The Comprehensive Diabetes Services Program shall be
21 developed and implemented only to the extent that state funds are
22 appropriated annually for the services provided under this section.

23 (f) The department shall develop and implement incentives for
24 Medi-Cal fee-for-service eligible beneficiaries who participate in
25 the Comprehensive Diabetes Services Program and are compliant
26 with program requirements for screening and self-management
27 activities.

28 (g) The department shall develop and implement financial
29 incentives for Medi-Cal fee-for-service providers who participate
30 in the Comprehensive Diabetes Services Program and are compliant
31 with program requirements in the screening and management of
32 eligible beneficiaries who have been diagnosed with prediabetes
33 and diabetes.

34 (h) The department shall collect data including, but not be
35 limited to, laboratory values from screening and diagnostic tests
36 for the individual beneficiaries participating in the Comprehensive
37 Diabetes Services Program and monitor the health outcomes of
38 the participating individual beneficiaries.

1 (i) The department shall, in consultation with the California
2 Diabetes Program in the State Department of Public Health,
3 contract with an independent organization to:

4 (1) Evaluate and report the health outcomes and cost savings
5 of the Comprehensive Diabetes Services program.

6 (2) Estimate the short- and long-term cost savings of expanding
7 the strategies of the Comprehensive Diabetes Services Program
8 statewide through the private or commercial insurance markets.

9 SEC. 76. Article 5.21 (commencing with Section 14167.1) is
10 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
11 Institutions Code, to read:

12
13 Article 5.21. Medi-Cal Hospital Rate Stabilization Act

14
15 14167.1. For purposes of this article, the following definitions
16 shall apply:

17 (a) “Acute inpatient day” means a fee-for-service day, as defined
18 for purposes of the Office of Statewide Health Planning and
19 Development reporting by hospitals, for which the hospital has
20 been paid by the Medi-Cal program where the Medi-Cal program
21 is the primary payer.

22 (b) “Base period” means the 12-month period ending on the
23 base period ending date. However, in the case of a hospital that
24 terminates a contract for the provision of hospital inpatient services
25 negotiated with the California Medical Assistance Commission
26 after the date this article is enacted and prior to the base period
27 ending date, the base period shall be the 12-calendar months prior
28 to the contract termination date.

29 (c) “Base period ending date” means the last day of the sixth
30 month immediately preceding the implementation date.

31 (d) “Contract hospital” means a hospital that has a written
32 contract with a managed health care plan to provide hospital
33 services to the plan’s subscribers or enrollees.

34 (e) “Designated public hospital” means any one of the following
35 hospitals:

- 36 (1) UC Davis Medical Center.
- 37 (2) UC Irvine Medical Center.
- 38 (3) UC San Diego Medical Center.
- 39 (4) UC San Francisco Medical Center.

1 (5) UC Los Angeles Medical Center, including Santa
2 Monica/UCLA Medical Center.

3 (6) LA County Harbor/UCLA Medical Center.

4 (7) LA County Olive View UCLA Medical Center.

5 (8) LA County Rancho Los Amigos National Rehabilitation
6 Center.

7 (9) LA County University of Southern California Medical
8 Center.

9 (10) Alameda County Medical Center.

10 (11) Arrowhead Regional Medical Center.

11 (12) Contra Costa Regional Medical Center.

12 (13) Kern Medical Center.

13 (14) Natividad Medical Center.

14 (15) Riverside County Regional Medical Center.

15 (16) San Francisco General Hospital.

16 (17) San Joaquin General Hospital.

17 (18) San Mateo Medical Center.

18 (19) Santa Clara Valley Medical Center.

19 (20) Ventura County Medical Center.

20 (f) “Hospital community” means the California Hospital
21 Association and any other hospital industry organization or system
22 that represents children’s hospitals, nondesignated public hospitals,
23 designated public hospitals, private safety net hospitals, and other
24 public or private hospitals.

25 (g) “Hospital inpatient services” means all services covered
26 under the Medi-Cal program and furnished by hospitals to patients
27 who are admitted as hospital inpatients and reimbursed on a
28 fee-for-service basis by the department directly or through its fiscal
29 intermediary. Hospital inpatient services include outpatient services
30 furnished by a hospital to a patient who is admitted to that hospital
31 within 24 hours of the provision of the outpatient services that are
32 related to the condition for which the patient is admitted. Hospital
33 inpatient services include physician services only if the service is
34 furnished to a hospital inpatient, the physician is compensated by
35 the hospital for the service, and the service is billed to the Medi-Cal
36 program by the hospital under a provider number assigned to the
37 hospital. Hospital inpatient services do not include inpatient mental
38 health services for which a county is financially responsible or
39 services furnished under a managed health care plan.

1 (h) “Hospital outpatient services” means all services covered
2 under the Medi-Cal program furnished by hospitals to patients
3 who are registered as hospital outpatients and reimbursed by the
4 department on a fee-for-service basis directly or through its fiscal
5 intermediary. Hospital outpatient services include physician
6 services only if the service is furnished to a hospital outpatient,
7 the physician is compensated by the hospital for the service, and
8 the service is billed to the Medi-Cal program by the hospital under
9 a provider number assigned to the hospital. Hospital outpatient
10 services do not include outpatient mental health services for which
11 a county is financially responsible or services furnished under a
12 managed health care plan.

13 (i) “Implementation date” means the first day on which hospitals
14 provide health care services to Medi-Cal beneficiaries that are
15 reimbursed under this article.

16 (j) “Inpatient base rate” means the per diem rate, or per discharge
17 rate if used by the department, established pursuant to Section
18 14167.4.

19 (k) “Managed health care plan” means a health care delivery
20 system that manages the provision of health care and receives
21 prepaid capitated payments from the state in return for providing
22 services to Medi-Cal beneficiaries. Managed health care plans
23 include, but are not limited to, county organized health systems
24 and entities contracting with the department to provide services
25 pursuant to two-plan models, geographic managed care, and
26 prepaid plans. Entities providing these services contract with the
27 department pursuant to Article 2.7 (commencing with Section
28 14087.3), Article 2.8 (commencing with Section 14087.5), or
29 Article 2.91 (commencing with Section 14089) of Chapter 7, or
30 Article 1 (commencing with Section 14200) or Article 7
31 (commencing with Section 14490) of Chapter 8.

32 (l) “Market basket index” means the percentage increase used
33 by the Medicare Program for the purpose of determining payment
34 rates for acute care inpatient hospital services as described in
35 Section 1886(b)(3)(B)(ii) of the federal Social Security Act.

36 (m) “Medi-Cal fee-for-service payments” means all payments
37 made by the Medi-Cal program to hospitals as reimbursement for
38 hospital inpatient services furnished with respect to acute inpatient
39 days, including payments for both routine and ancillary services,
40 and payments described in subdivision (e) of Section 14167.4, but

1 excluding payments described in subdivision (f) of Section
2 14167.4.

3 (n) “New hospital” means a hospital that did not provide hospital
4 inpatient services to Medi-Cal beneficiaries under current or prior
5 ownership and has no history of Medi-Cal reimbursement.

6 (o) “Nondesignated public hospital” means a public hospital
7 that is licensed under subdivision (a) of Section 1250 of the Health
8 and Safety Code and is defined in paragraph (25) of subdivision
9 (a) of Section 14105.98, excluding designated public hospitals.

10 (p) “Outpatient base rates” means the Medi-Cal payment rates
11 for hospital outpatient services in effect on the date immediately
12 preceding the implementation date.

13 (q) “Private hospital” means a hospital licensed under
14 subdivision (a) of Section 1250 of the Health and Safety Code that
15 is a nonpublic hospital, nonpublic-converted hospital, or converted
16 hospital as those terms are defined in paragraphs (26) to (28),
17 inclusive, respectively, of subdivision (a) of Section 14105.98.

18 (r) “Safety net care pool” means the federal funds available to
19 ensure continued government support for the provision of health
20 care services to uninsured populations, as described in subdivision
21 (k) of Section 14166.1.

22 14167.2. (a) The department shall determine outpatient base
23 rates for hospital outpatient services furnished by nondesignated
24 public hospitals based on the payment methodology in effect on
25 the day immediately preceding the implementation date until the
26 department has developed new methods and standards for payment
27 of hospital outpatient services under subdivision (b). The
28 department shall increase the outpatient base rates by the
29 percentage the department determines is necessary to comply with
30 subdivision (c) so that each outpatient base rate is increased by
31 the same percentage, except as may be necessary to comply with
32 federal Medicaid law.

33 (b) The department, in consultation with the hospital community,
34 and with input from others as deemed necessary and appropriate,
35 shall develop new methods and standards of payment for hospital
36 outpatient services. These new methods and standards shall
37 implement subdivision (c) and take into consideration factors such
38 as acuity and the cost incurred by hospitals in providing services.

39 (c) Medi-Cal rates for hospital outpatient services furnished by
40 nondesignated public hospitals during a fiscal year shall be set to

1 result in aggregate payments equal to the maximum permitted by
2 federal Medicaid law.

3 (d) The department shall establish rates of payment pursuant to
4 this section prior to the implementation date and prior to the
5 beginning of each state fiscal year commencing on or after the
6 implementation date. The department shall monitor payments
7 during the fiscal year and may make adjustments as may be
8 necessary to comply with subdivision (c).

9 14167.3. (a) The department shall determine outpatient base
10 rates for hospital outpatient services furnished by private hospitals
11 based on the payment methodology in effect on the day
12 immediately preceding the implementation date until the
13 department has developed new methods and standards for payment
14 of hospital outpatient services under subdivision (b). The
15 department shall increase the outpatient base rates by the
16 percentage the department determines is necessary to comply with
17 subdivision (c) so that each outpatient base rate is increased by
18 the same percentage, except as may be necessary to comply with
19 federal Medicaid law.

20 (b) The department, in consultation with the hospital community,
21 and with input from others as deemed necessary and appropriate,
22 shall develop new methods and standards of payments for hospital
23 outpatient services. These new methods and standards shall
24 implement subdivision (c) and take into consideration factors such
25 as acuity and the cost incurred by hospitals in providing services.

26 (c) Medi-Cal rates for hospital outpatient services furnished by
27 private hospitals during a fiscal year shall be set to result in
28 aggregate payments equal to the maximum permitted by federal
29 Medicaid law.

30 (d) The department shall establish rates of payment pursuant to
31 this section prior to the implementation date and prior to the
32 beginning of each state fiscal year commencing on or after the
33 implementation date. The department shall monitor payments
34 during the fiscal year and may make adjustments as may be
35 necessary to comply with subdivision (c).

36 14167.4. (a) The department shall determine an inpatient base
37 rate for each private hospital and nondesignated public hospital.

38 (b) The inpatient base rate shall be an estimate of the hospital's
39 Medi-Cal fee-for-service payments per acute inpatient day, or per

1 acute inpatient discharge if used by the department, as of the day
2 immediately preceding the implementation date.

3 (c) Each hospital's inpatient base rate shall be determined as
4 follows:

5 (1) The department shall determine the hospital's total Medi-Cal
6 fee-for-service payments for services furnished during the base
7 period.

8 (2) The department shall determine the hospital's total Medi-Cal
9 acute inpatient days, or the number of acute inpatient discharges
10 if used by the department, for the base period.

11 (3) The department shall divide the result of paragraph (1) by
12 the result of paragraph (2).

13 (4) The department shall adjust the result of paragraph (3) by
14 the rate of increase in the market basket index from the midpoint
15 of the base period to the implementation date. The result shall be
16 the hospital's inpatient base rate.

17 (d) The department shall make available a paid claims summary
18 for each hospital that sets forth all of the Medi-Cal fee-for-service
19 payments made for services furnished during the hospital's base
20 period and the hospital's fee-for-service Medi-Cal acute inpatient
21 days for the base period, and any other data the department may
22 require to determine each hospital's base rate. The Medi-Cal
23 fee-for-service payments for hospitals reimbursed on a cost basis
24 shall be the hospital's interim payments. The department shall use
25 this data to compute the inpatient base rate.

26 (e) The department shall add to each hospital's Medi-Cal
27 fee-for-service payments set forth in the paid claims summary
28 prepared pursuant to subdivision (d) the supplemental payments
29 under Section 14166.12 or Section 14166.17 made by the
30 department to the hospital with respect to the state fiscal year
31 ending during the base period.

32 (f) In determining each hospital's inpatient base rate, the
33 department shall exclude payments made pursuant to Sections
34 14085.5, 14166.11, 14166.16, 14166.21, and 14166.23, payments
35 by a managed health care plan or one of its contractors, payments
36 resulting from an intergovernmental transfer, or payments made
37 where the Medi-Cal program is not the primary payer, such as
38 services covered under Medicare Part A and Part B where the
39 individual receiving the services is a Medi-Cal beneficiary.

1 (g) The department shall make available a preliminary list of
2 each hospital's inpatient base rate and provide each hospital with
3 the data used to compute its base rate no later than 90 days before
4 the implementation date. The department shall make available a
5 final list of each hospital's inpatient base rate 30 days prior to the
6 implementation date.

7 (h) A hospital's base rate shall be corrected if the hospital
8 demonstrates any of the following:

9 (1) The department made a mathematical error.

10 (2) The data used by the department is inaccurate based on the
11 data in the possession of the department or its fiscal intermediary
12 at the time the paid claims summary under subdivision (d) was
13 prepared. Payments made after the date of the preparation of the
14 paid claims summary under subdivision (d) shall not be a ground
15 for correction.

16 (3) The department failed to include payments described in
17 subdivision (e).

18 (4) The department included payments described in subdivision
19 (f).

20 (i) The inpatient base rate for a new hospital shall be the median
21 base rate of hospitals in the peer group to which the new hospital
22 is assigned by the department. The peer groups are those groupings
23 of hospitals described in Section 51553 of Title 22 of the California
24 Code of Regulations.

25 (j) The department shall review and issue a determination
26 concerning a hospital's request for a correction under subdivision
27 (h) within 30 days of receipt of the request. Any correction that is
28 made shall be applied prospectively, beginning the first day of the
29 first calendar quarter beginning after the date of the department's
30 determination. However, if the department receives a hospital's
31 request for a correction no later than 30 days after the department
32 publishes the preliminary list under subdivision (g), any correction
33 shall be effective as of the implementation date.

34 (k) The department shall develop an informal process for
35 reviewing and making decisions promptly concerning disputes by
36 hospitals of the department's action or proposed action under this
37 section or Section 14167.5, consistent with the provisions of this
38 section and Section 14167.5. The process shall be exempt from
39 the provisions of the Administrative Procedure Act.

1 (l) Notwithstanding any other provision of law, no change to a
2 hospital's base rate shall be applied to payments for services
3 rendered prior to the effective date of the change to the base rate.

4 14167.5. To the extent feasible, the department shall develop
5 a case mix adjustment factor to apply to inpatient base rates for
6 private and nondesignated public hospitals. If developed, the
7 department shall take all of the following steps:

8 (a) Each private and nondesignated public hospital's inpatient
9 base rate shall be adjusted to reflect changes in the hospital's
10 Medi-Cal case mix for fee-for-service Medi-Cal inpatients as
11 compared to the base period.

12 (b) Case mix adjustments shall be applied prospectively at the
13 beginning of each state fiscal year beginning with the first state
14 fiscal year that begins no less than 12 months after the
15 implementation date.

16 (c) The department shall compute a case mix adjustment factor
17 for each hospital for each state fiscal year. The case mix adjustment
18 factor shall be the hospital's case mix index for the most recent
19 calendar year divided by the case mix index for the base period.

20 (d) The department, in consultation with the hospital community,
21 and with input from others as deemed necessary and appropriate,
22 shall develop the methodology for computing the case mix index,
23 including the data to be used and the sources of the data. In
24 developing the case mix index methodology, the department shall
25 consider, at minimum, the following factors:

26 (1) The development of a methodology that reasonably measures
27 the relative cost that would be expected to be incurred in treating
28 different types of cases.

29 (2) The use of an approach using diagnosis-related groups and
30 relative weights for those groups used by the Medicare Program
31 under the Medicare inpatient prospective payment system.

32 (3) The accuracy of applying weights used by the Medicare
33 Program for the purpose of measuring the Medi-Cal case mix.

34 (4) The available data.

35 (5) The comparability of the data available for the base period
36 and the data available for later years.

37 (6) The development of accurate measures of relative case mix
38 for pediatric patients.

39 (e) No later than 90 days prior to the beginning of the fiscal
40 period to which a case mix adjustment factor is applied, the

1 department shall determine each hospital’s case mix adjustment
2 factor, advise each hospital of its case mix adjustment factor and
3 the case mix index factors used to compute the case mix adjustment
4 factor, and provide each hospital with the data used to compute
5 the case mix adjustment factor.

6 (f) A hospital’s case mix adjustment factor shall be corrected
7 if the hospital demonstrates any of the following:

- 8 (1) The department made a mathematical error.
- 9 (2) The data used by the department is inaccurate.
- 10 (3) More accurate data is available.

11 (g) The department shall review and issue a determination
12 concerning a hospital’s request for a correction under subdivision
13 (f) within 30 days of receipt of the request. Any correction that is
14 made shall be applied prospectively, beginning the first day of the
15 first calendar quarter beginning after the date of the department’s
16 determination.

17 (h) (1) The department may make adjustments to a hospital’s
18 base rate to take into account an event or series of events that may
19 significantly affect a hospital’s costs of furnishing hospital inpatient
20 services that is not reflected in the case mix adjustment, such as a
21 merger or consolidation of hospitals, a substantial change in the
22 types of services furnished by a hospital, or a substantial change
23 in the acuity of the hospital’s patients. An event or series of events
24 shall be deemed to significantly affect a hospital’s costs only if
25 the department determines that the hospital’s cost per day has
26 increased or decreased by 10 percent or more as a result of the
27 event or series of events. Events that are generally applicable to
28 multiple hospitals, such as a market basket increase in the costs
29 of goods or services purchased by hospitals, shall not be a basis
30 for an adjustment under this subdivision.

31 (2) The department shall notify the hospital in writing of any
32 adjustment it proposes to make under this subdivision. The notice
33 shall include an explanation of the department’s reasons for making
34 the adjustment, the computation of the adjustment, and the data
35 relied on by the department in making the adjustment. The hospital
36 may dispute an adjustment within 30 days after receipt of the notice
37 described in this paragraph by providing written notice to the
38 person identified by the department in the notice. The hospital
39 shall include in the written notice of dispute the reasons the hospital
40 believes the adjustment should not be made as proposed by the

1 department, including all data supporting the hospital's position.
2 The department may not implement any adjustment under this
3 subdivision until it makes a final determination concerning a notice
4 of dispute.

5 (3) Any adjustment under this subdivision shall be made
6 prospectively beginning the first day of the calendar quarter
7 beginning no sooner than 60 days after the department issues a
8 notice to the hospital of the proposed adjustment. However, if the
9 hospital timely disputes the proposed adjustment, as specified in
10 paragraph (2), the proposed adjustment shall not be implemented
11 until the first day of the first calendar quarter beginning after the
12 department issues its decision concerning the dispute.

13 14167.6. (a) The department shall determine inpatient base
14 rates pursuant to Section 14167.4 for hospital inpatient services
15 provided by nondesignated public hospitals based on the payment
16 methodologies in effect on the day immediately preceding the
17 implementation date until the department has developed new
18 methods and standards under subdivision (b). The department shall
19 increase each hospital's inpatient base rate by the percentage the
20 department determines is necessary to comply with subdivision
21 (c), taking into account the additional payments made pursuant to
22 subdivision (e), so that each hospital's inpatient base rate is
23 increased by the same percentage, except as may be necessary to
24 comply with federal Medicaid law. The department shall pay each
25 nondesignated public hospital for hospital inpatient services
26 provided prior to the implementation of new methods and standards
27 of payment developed pursuant to subdivision (b) based on its
28 inpatient base rate as increased pursuant to this subdivision.

29 (b) The department, in consultation with the hospital community,
30 and with input from others as deemed necessary and appropriate,
31 shall develop new methods and standards of payments for hospital
32 inpatient services provided by nondesignated public hospitals.
33 These new methods and standards shall implement subdivision (c)
34 and take into consideration factors such as patient acuity, the cost
35 incurred by hospitals in providing services, and equitable payment
36 for outlier patients.

37 (c) Medi-Cal rates for hospital inpatient services furnished by
38 nondesignated public hospitals during a state fiscal year shall be
39 set at an amount that results in aggregate payments equal to the
40 maximum permitted by federal Medicaid law.

1 (d) The department shall establish rates of payment pursuant to
2 this section prior to the implementation date and prior to the
3 beginning of each state fiscal year beginning on or after the
4 implementation date. The department shall monitor payments
5 during the fiscal year, and may make adjustments that may be
6 necessary to comply with subdivision (c).

7 (e) The department shall develop a reimbursement methodology
8 to equitably compensate nondesignated public hospitals for the
9 delivery of Medi-Cal acute inpatient psychiatric services.

10 14167.7. (a) The department shall determine inpatient base
11 rates pursuant to Section 14167.4 for hospital inpatient services
12 provided by private hospitals based on the payment methodologies
13 in effect on the day immediately preceding the implementation
14 date until the department has developed new methods and standards
15 under subdivision (b). The department shall increase each hospital's
16 inpatient base rate by the percentage the department determines
17 is necessary to comply with subdivision (c), taking into account
18 the additional payments made under subdivision (f), so that each
19 hospital's inpatient base rate is increased by the same percentage,
20 except as may be necessary to comply with federal Medicaid law.
21 The department shall pay each private hospital for hospital
22 inpatient services provided prior to the implementation of new
23 methods and standards of payment developed pursuant to
24 subdivision (b) based on its inpatient base rate as increased
25 pursuant to this subdivision.

26 (b) The department, in consultation with the hospital community,
27 and with input from others as deemed necessary and appropriate,
28 shall develop new methods and standards of payments for hospital
29 inpatient services provided by private hospitals. These new
30 methods and standards shall implement subdivision (c) and take
31 into consideration factors such as patient acuity, the cost incurred
32 by hospitals in providing services, and equitable payment for outlier
33 patients.

34 (c) Medi-Cal rates for hospital inpatient services furnished by
35 private hospitals during a state fiscal year shall be set to result in
36 aggregate payments equal to the maximum permitted by federal
37 Medicaid law.

38 (d) The department shall establish rates of payment pursuant to
39 this section prior to the implementation date and prior to the
40 beginning of each state fiscal year beginning on or after the

1 implementation date. The department shall monitor payments
2 during the fiscal year and may make such adjustments as may be
3 necessary to comply with subdivision (c).

4 (e) Subject to subdivision (c) of Section 14167.12, the
5 department shall establish rates of payment to major teaching
6 institutions that have a formal academic affiliation with a
7 designated public hospital or a private or public California medical
8 school that take into consideration the cost of medical education
9 programs.

10 (f) The department shall develop a reimbursement methodology
11 to equitably compensate private hospitals for the delivery of
12 Medi-Cal acute inpatient psychiatric services.

13 14167.8. (a) The amount of any increased payments made
14 under this article to private hospitals in excess of the payments
15 that would have been made under the payment rates in effect on
16 the day immediately prior to the implementation date, including
17 the amount of increased payments to hospitals by managed health
18 care plans pursuant to Section 14167.9, shall not be included in
19 the calculation of the numerator or denominator of the low-income
20 percent of the OBRA limit for purposes of the disproportionate
21 share hospital replacement fund payments pursuant to Section
22 14166.11.

23 (b) The department shall continue to make payments to private
24 and nondesignated public hospitals pursuant to Sections 14085.5,
25 14105.17, 14105.97, 14166.11, and 14166.16, in addition to other
26 payments made under this article. The department shall take all of
27 these payments into account in determining whether an applicable
28 federal limitation is satisfied only if, and to the extent, required
29 by federal Medicaid law.

30 (c) Each private and nondesignated public hospital, as a
31 condition of receiving reimbursement under this section, shall
32 keep, maintain, and have readily retrievable, any records specified
33 by the department to fully support reimbursement amounts to
34 which the hospital is entitled, and any other records required by
35 the federal Centers for Medicare and Medicaid Services.

36 14167.9. (a) The director shall increase reimbursement rates
37 to managed health care plans by the actuarial equivalent amount
38 necessary to ensure that managed health care plans increase rates
39 of payments to hospitals under their contracts by the same
40 percentage that Medi-Cal fee-for-service rates to hospitals are

1 increased pursuant to this article, subject to the limitations of
2 federal Medicaid law, if any.

3 (b) Subject to subdivision (c), as applicable, the department
4 shall further increase payments to managed health care plans, in
5 addition to any increased payments made under subdivision (a),
6 as may be necessary to ensure that the full amount of the revenue
7 arising from payments of a fee from all hospitals subject to the fee
8 for patient days in a fiscal year is expended after making the
9 expenditures for the payments under Sections 14167.2, 14167.3,
10 14167.6, 14167.7, and 14167.10.

11 (c) (1) The amount of increased payments under this section
12 shall not exceed either of the following limits:

13 (A) The maximum amount, if any, for which federal financial
14 participation may be claimed.

15 (B) The sum of available revenue derived from a fee, as
16 described in subdivision (l) of Section 14167.12, plus interest,
17 penalties, and federal financial participation.

18 (2) The revenue derived from a fee, as described in subdivision
19 (l) of Section 14167.12, that is made available for purposes of this
20 section shall be 23.29 percent of the total fees that are assessed on
21 nondesignated public and private hospitals with respect to any
22 fiscal year.

23 (d) A Medi-Cal managed care plan shall equitably expend, in
24 the form of increased rates to all private hospitals, nondesignated
25 public hospitals, and designated public hospitals, for providing
26 services to Medi-Cal patients, 100 percent of any rate increase it
27 receives under this section. Managed health care plans shall submit
28 documentation as the department may require to demonstrate
29 compliance with the provisions of this subdivision.

30 14167.10. (a) (1) Commencing July 1, 2010, designated public
31 hospitals shall receive Medi-Cal reimbursement as specified in
32 this section.

33 (2) For purposes of this section, “hospital services” means
34 inpatient services and services rendered in the outpatient
35 department of the hospital, excluding services rendered by a
36 hospital-based federally qualified health center for which
37 reimbursement is received pursuant to Section 14132.100.

38 (b) Notwithstanding Article 2.6 (commencing with Section
39 14081), Sections 14166.35 to 14166.9, inclusive, and any other
40 provision of law, each of the designated public hospitals shall be

1 paid for those hospital services provided to Medi-Cal beneficiaries
2 on a fee-for-service basis during any fiscal year as follows:

3 (1) Except as provided in paragraph (5), each of the designated
4 public hospitals shall receive, as payment for inpatient hospital
5 services provided to Medi-Cal beneficiaries during any fiscal year,
6 amounts based on the hospital's allowable costs incurred in
7 providing those services. These costs shall be determined annually
8 by the department making use of the data provided pursuant to
9 subdivision (c).

10 (2) Except as provided in paragraph (5), for the 2010–11 fiscal
11 year, and each fiscal year thereafter, each of the designated public
12 hospitals shall receive a reimbursement rate, limited to the
13 payments funded using state funds as provided in paragraph (3),
14 for the estimated cost of inpatient and outpatient hospital services
15 rendered to Medi-Cal beneficiaries based upon claims filed by the
16 hospital in accordance with the claims process set forth in Division
17 3 (commencing with Section 50000) of Title 22 of the California
18 Code of Regulations. Estimated costs shall be derived pursuant to
19 the process set forth in subdivision (b) of Section 14166.4. Costs
20 not reimbursed pursuant to this paragraph shall be reimbursed
21 pursuant to paragraph (7). Inpatient hospital rates may be on a per
22 diem or per discharge basis as determined by the department.

23 (3) (A) (i) The nonfederal share of the reimbursement specified
24 in paragraph (2) shall consist of state funds, which shall be
25 established for fiscal year 2010–11 through and including fiscal
26 year 2012–13 at the nonfederal share of the full cost incurred by
27 the particular hospital in the 2009–10 fiscal year, adjusted annually
28 by the percentage increase in the medical component of the
29 Consumer Price Index-Urban for the United States, but not to
30 exceed the nonfederal share of allowable, actual costs. For purposes
31 of this paragraph, the 2009–10 fiscal year shall be the hospital's
32 initial base year.

33 (ii) Notwithstanding clause (i), the nonfederal share of
34 reimbursement available for the purposes of paragraph (2) shall
35 be reduced annually by the amount of twenty-five million dollars
36 (\$25,000,000), which amount of state funds shall be made available
37 for purposes of subdivision (g).

38 (B) For purposes of this paragraph, the nonfederal share shall
39 be calculated by subtracting the federal medical assistance
40 percentage in effect for the particular fiscal year from 100 percent.

1 (C) (i) For fiscal year 2013–14 and each fiscal year thereafter,
 2 the nonfederal share of the reimbursement specified in paragraph
 3 (2), as reduced pursuant to clause (ii) of subparagraph (A), shall
 4 consist of state funds, which shall be established at the nonfederal
 5 share of the full cost incurred by the particular hospital in the
 6 hospital’s base year, adjusted annually by the percentage increase
 7 in the medical component of the Consumer Price Index-Urban for
 8 the United States, but not to exceed the nonfederal share of
 9 allowable, actual costs.

10 (ii) At the beginning of each three-year period beginning with
 11 the three-year period commencing on July 1, 2013, each hospital’s
 12 costs incurred, for purposes of clause (i), shall be determined to
 13 be the full cost incurred by the particular hospital in the fiscal year
 14 beginning two years prior to the beginning of the new three-year
 15 period, which fiscal year shall be the hospital’s new base year.

16 (4) For the 2010–11 fiscal year, and each fiscal year thereafter,
 17 each designated public hospital shall receive supplemental federal
 18 reimbursement pursuant to Section 14105.96, in addition to the
 19 reimbursement received by each hospital for outpatient services
 20 pursuant to paragraph (2).

21 (5) Reimbursement paid to Federally Qualified Health Centers
 22 shall continue pursuant to Section 14132.100 for those hospitals
 23 that were designated by the state as Federally Qualified Health
 24 Centers as of July 1, 2007.

25 (6) The cost data and the resulting estimated costs submitted
 26 pursuant to this section shall be certified as accurate by the unit
 27 of government that owns or operates the hospital submitting the
 28 estimated costs. Certifications required by this paragraph shall
 29 comply with the requirements of subdivision (e) of Section
 30 14166.8.

31 (7) (A) To the extent that the amount of the estimated allowable
 32 costs for each designated public hospital determined pursuant to
 33 paragraph (1) exceeds the amounts actually paid pursuant to
 34 paragraph (2), the hospital shall receive a quarterly supplemental
 35 payment equal to the federal reimbursement received as a result
 36 of the amounts claimed by the department to the federal
 37 government based on the total amounts certified pursuant to
 38 paragraph (6).

39 (B) Services provided by clinics and hospital outpatient
 40 departments for which reimbursement is made under a cost-based

1 methodology pursuant to Section 14105.24 shall continue to be
2 reimbursed under that methodology.

3 (C) The supplemental Medi-Cal reimbursement provided by
4 this paragraph shall be distributed quarterly under a payment
5 methodology based on inpatient services provided to Medi-Cal
6 patients at the eligible facility, either on a per-visit basis,
7 per-procedure basis, or any other federally permissible basis.

8 (D) Payments made pursuant to this paragraph shall be subject
9 to reconciliation pursuant to subdivision (f), and pursuant to any
10 other applicable requirement of state or federal law.

11 (c) (1) Within five months after the end of each fiscal year,
12 each designated public hospital shall submit to the department
13 both of the following reports:

14 (A) The hospital's Medi-Cal cost report for the fiscal year.

15 (B) Other cost reporting and statistical data necessary for the
16 determination of amounts due the hospital, as requested by the
17 department.

18 (2) For each fiscal year, the reports shall identify the costs
19 incurred in providing inpatient hospital services to Medi-Cal
20 beneficiaries on a fee-for-service basis.

21 (3) Reports submitted under this subdivision shall include all
22 allowable costs.

23 (d) Designated public hospitals shall receive disproportionate
24 share hospital payments pursuant to Section 14166.6.

25 (e) In the event of a conflict between the provisions of this
26 section and any provision of Article 5.2 (commencing with Section
27 14166), the provisions of this section shall govern. In addition to
28 direct conflicts, if continuing the implementation or application
29 of any of the provisions of Article 5.2 (commencing with Section
30 14166) leads to results that are inconsistent with the payment
31 methodology established in this section, after consultation with
32 representatives of the designated public hospitals, the director shall
33 not implement or apply any provision of Article 5.2 (commencing
34 with Section 14166) that the director determines has those results.

35 (f) No later than April 1 following the end of the fiscal year,
36 the department shall undertake an interim reconciliation of
37 payments made pursuant to this section based on the hospitals'
38 Medi-Cal cost reports and other cost and statistical data submitted
39 by the hospitals for the fiscal year and shall adjust payments to
40 each hospital accordingly.

1 (g) (1) (A) The amount of twenty-five million dollars
2 (\$25,000,000), made available pursuant to subparagraph (A) of
3 paragraph (3) of subdivision (b), shall be transferred to the
4 Workforce Development Program Fund established pursuant to
5 subparagraph (B).

6 (B) The Workforce Development Program Fund is hereby
7 established in the State Treasury. For purposes of this subdivision,
8 “fund” means the Workforce Development Program Fund.

9 (1) Moneys in the fund shall, upon appropriation, be used
10 exclusively for retraining county hospital and clinic systems’ health
11 care workers.

12 (2) Any moneys remaining in the fund at the end of a fiscal year
13 shall be carried forward for use in the following fiscal year.

14 (3) Moneys in the fund shall, upon appropriation, be allocated
15 from the fund by the Office of Statewide Health Planning and
16 Development.

17 (4) By May 1, 2010, counties shall develop and submit work
18 plans to the Office of Statewide Health Planning and Development
19 for the implementation of programs and needed investments for
20 workforce training that are consistent with the implementation of
21 health care reform at the county level. The Office of Statewide
22 Health Planning and Development shall provide comments on the
23 work plan within 45 days from the date of submission of the work
24 plan and allocate funds from the fund within 90 days.

25 (5) Allocations from the fund shall recognize successful training
26 programs, either through existing labor-management training
27 partnerships, or emerging intracounty labor management-initiatives.

28 (6) Federal financial participation shall be claimed for
29 expenditures under this subdivision only as authorized by federal
30 law and regulations.

31 (h) This section shall be implemented only to the extent that
32 counties with designated public hospitals seeking reimbursement
33 under this section contribute toward the cost of care through a
34 county share of cost.

35 14167.11. (a) Notwithstanding Article 5.2 (commencing with
36 Section 14166), for the period of time during which this article is
37 operative, safety net care pool funds, as defined in subdivision (r)
38 of Section 14167.1, shall be paid to the designated public hospitals,
39 as defined in subdivision (e) of Section 14167.1, in accordance
40 with this section, to the extent that those funds are available.

1 (b) (1) Each designated public hospital, or the governmental
2 entity with which it is affiliated, that operates nonhospital clinics
3 or provides other health care services that are not identified as
4 hospital services, may report and certify, in accordance with
5 Section 14166.8, all or a portion of its uncompensated costs of the
6 services furnished to the uninsured. Each designated public
7 hospital, or the governmental entity with which it is affiliated, shall
8 receive from the safety net care pool for each fiscal year an amount
9 equal to the federal funds derived from the certification of
10 uncompensated care costs pursuant to the preceding sentence. The
11 maximum amount payable pursuant to this paragraph shall be one
12 hundred million dollars (\$100,000,000).

13 (2) If, for any fiscal year, the amount payable from the safety
14 net care pool is insufficient for purposes of the payments described
15 in paragraph (1), each designated public hospital, or governmental
16 entity with which it is affiliated, shall receive a pro rata share of
17 the amount specified in paragraph (1). The pro rata amount
18 determined for purposes of this paragraph shall be based on the
19 percentage that each designated public hospital's certified
20 uncompensated medical care costs of medical services provided
21 to uninsured individuals bears to the total amount of the costs
22 certified by all of the participating designated public hospitals or
23 governmental entity with which it is affiliated.

24 (3) Safety net care pool funds above one hundred million dollars
25 (\$100,000,000) in any state fiscal year shall be claimed by the
26 director for the state's expenditures under Section 14005.333 and
27 under Part 6.45 (commencing with Section 12699. 201) of Division
28 2 of the Insurance Code.

29 (4) If the expenditures specified in paragraph (3) are insufficient
30 to claim the full amount of safety net care pool funds available in
31 any state fiscal year, and the designated public hospitals, or
32 governmental entities with which they are affiliated, have certified
33 expenditures in the aggregate in excess of the amount necessary
34 to make the payments required by this subdivision, the department
35 shall seek Medicaid federal financial participation from the safety
36 net care pool to the maximum extent possible based on the
37 remaining certified public expenditures of the designated public
38 hospitals and governmental entities with which they are affiliated,
39 and shall distribute the funds to the designated public hospitals,
40 or governmental entities with which they are affiliated, based on

1 the amount of each entity’s certified expenditures. If the designated
2 public hospitals’ remaining certified public expenditures exceed
3 the amount of available safety net care pool funds, the amounts
4 remaining in the safety net care pool, when claimed, shall be
5 distributed on a pro rata basis.

6 (5) Subdivision (a) of Section 14166.21 shall remain operative
7 for the period of time during which this article is operative, but
8 subdivision (b) of Section 14166.21 shall be inoperative for the
9 period of time during which this article is operative.

10 (c) Except as provided in subdivision (b), subdivision (g) of
11 Section 14166.8 shall be inoperative for the period of time during
12 which this article is operative. The department shall seek Medicaid
13 federal financial participation from the safety net care pool based
14 on qualifying expenditures from the designated public hospitals
15 or governmental entity with which it is affiliated.

16 (d) Payments and funding described in this section shall be
17 subject to the availability of federal funds through a demonstration
18 project approved by the federal government pursuant to Section
19 1115 of the federal Social Security Act.

20 (e) The director may suspend, modify, or adjust any
21 methodology or computation required by Article 5.2 (commencing
22 with Section 14166) that is necessary to implement this section.

23 14167.12. (a) The department shall consult with the hospital
24 community, and shall receive input from others as deemed
25 necessary and appropriate, in developing and implementing any
26 and all payment methodologies developed or implemented for
27 purposes of this article. The consultation, with input from others
28 as deemed necessary and appropriate, shall occur sufficiently in
29 advance of the publication of any proposed regulation pertaining
30 to any such payment methodology so as to allow the hospital
31 community, and others as deemed necessary and appropriate, to
32 have meaningful participation and offer comments as well as to
33 allow the department an opportunity to consider additional
34 information and engage in follow-up discussions.

35 (b) The director shall seek federal approval of each payment
36 methodology set forth in this article. The director, in consultation
37 with the hospital community, and with input from others as deemed
38 necessary and appropriate, may alter any methodology specified
39 in this article to the extent necessary to meet the requirements of
40 federal law or regulations or to obtain federal approval. If, after

1 seeking federal approval, federal approval is not obtained, that
2 methodology shall not be implemented.

3 (c) Payments made pursuant to this article are contingent on the
4 receipt of federal reimbursement.

5 (d) In implementing this article, the department may utilize the
6 services of the Medi-Cal fiscal intermediary through a change
7 order to the fiscal intermediary contract to administer this program,
8 consistent with the requirements of Sections 14104.6, 14104.7,
9 14104.8, and 14104.9. Contracts entered into with any Medicare
10 fiscal intermediary shall not be subject to Part 2 (commencing with
11 Section 10100) of Division 2 of the Public Contract Code.

12 (e) Except as otherwise provided in this article, Sections
13 14166.11 to 14166.14, inclusive, Sections 14166.17 to 14166.20,
14 inclusive, and Sections 14166.22 and 14166.23, shall be inoperative
15 for the period of time during which this article is operative.

16 (f) This article shall become inoperative five years after the
17 implementation date of this article and as of January 1, 2016, is
18 repealed, unless a later enacted statute that is enacted on or before
19 January 1, 2016, extends or deletes the dates on which it becomes
20 inoperative and is repealed.

21 (g) This article shall be applicable to services rendered to
22 Medi-Cal beneficiaries on and after July 1, 2010. For services that
23 are paid under this article, any other provider rate methodology,
24 including those established by the California Medical Assistance
25 Commission pursuant to Article 2.6 (commencing with Section
26 14081), shall become inoperative for those services on and after
27 that date.

28 (h) This article shall not apply to any service furnished prior to
29 the effective date of any federal approvals that may be required to
30 ensure the availability of federal financial participation for
31 expenditures made pursuant to this article.

32 (i) This article shall become inoperative in the event, and on
33 the effective date, of a final judicial determination by any court of
34 appellate jurisdiction or a final determination by the federal
35 Department of Health and Human Services or the Centers for
36 Medicare and Medicaid Services that any element of this article
37 cannot be implemented.

38 (j) The department shall implement this article only to the extent
39 that state funds are appropriated for the nonfederal share of the
40 rate increases provided in this article.

1 (k) If this article becomes inoperative, hospitals shall be paid
2 the rates that were in effect on June 30, 2010, including the rates
3 paid pursuant to the provision of Article 2.6 (commencing with
4 Section 14081).

5 (l) This article shall be implemented only during those fiscal
6 years in which a 4 percent fee is imposed on the net patient revenue
7 of general acute care hospitals.

8 SEC. 77. Article 5.215 (commencing with Section 14167.22)
9 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
10 Institutions Code, to read:

11
12 Article 5.215. Medi-Cal Physician Services Rate Increase Act
13

14 14167.22. (a) The director shall seek federal approval of the
15 rate methodology set forth in this article. The director may alter
16 any methodology specified in this article, to the extent necessary
17 to meet the requirements of federal law or regulations or to obtain
18 federal approval. If, after seeking federal approval, federal approval
19 is not obtained, that methodology shall not be implemented.

20 (b) Payments made pursuant to this article are contingent on
21 the receipt of federal reimbursement. Unless otherwise expressly
22 provided in this article, nothing in this article shall create an
23 obligation on the part of the department to fund any payment from
24 state funds in the absence of, or on account of a shortfall in, federal
25 funding.

26 (c) The director shall increase reimbursement rates to managed
27 health care plans by the actuarially equivalent amount necessary
28 to ensure that managed health care plans increase rates of payment
29 to the classes of providers whose rates are governed by this article
30 at the same percentage increase that Medi-Cal fee-for-service rates
31 are increased to the same classes of providers pursuant to this
32 article, subject to the limitations of federal law, if any.

33 14167.23. For purposes of this article, the following definitions
34 shall apply:

35 (a) “Nonphysician medical practitioner” means a physician’s
36 assistant, a certified nurse midwife, or a nurse practitioner, who
37 provides primary care services, as defined in Section 51170.5 of
38 Title 22 of the California Code of Regulations, who is an enrolled
39 Medi-Cal provider eligible to receive Medi-Cal payments, and
40 who provides physician services to Medi-Cal beneficiaries. Primary

1 care physician services rendered by nonphysician medical
2 practitioners are covered as physician services to the extent
3 permitted by applicable licensing statutes and regulations. The
4 terms “physician’s assistant,” “nurse midwife,” and “nurse
5 practitioner” are defined for purposes of this article in Sections
6 51170.1, 51170.2, and 51170.3 of Title 22 of the California Code
7 of Regulations, respectively.

8 (b) “Physician” means a practitioner meeting the requirements
9 of Section 51228 of Title 22 of the California Code of Regulations
10 who is an enrolled Medi-Cal provider eligible to receive Medi-Cal
11 payments and who provides physician services to Medi-Cal
12 beneficiaries.

13 (c) “Physician group” means two or more physicians legally
14 organized as a partnership, professional corporation, foundation,
15 not-for-profit corporation, or similar association that meets the
16 requirements of Section 51000.16 of Title 22 of the California
17 Code of Regulations and that is an enrolled Medi-Cal provider
18 eligible to receive Medi-Cal payments and provides physician
19 services to Medi-Cal beneficiaries.

20 (d) “Physician services” means those services as described in
21 Section 51305 of Title 22 of the California Code of Regulations.

22 (e) “Podiatrist” means a person as defined in Section 51075 of
23 Title 22 of the California Code of Regulations who is an enrolled
24 Medi-Cal provider eligible to receive Medi-Cal payments and who
25 provides physician services to Medi-Cal beneficiaries.

26 (f) “Clinic” means an organized outpatient health facility as
27 defined in Section 1200 of the Health and Safety Code.

28 14167.24. (a) A physician, physician group, clinic, podiatrist,
29 or nonphysician medical practitioner shall receive Medi-Cal
30 reimbursement to the extent provided in this section.

31 (b) Physician services, including those rendered by physicians,
32 physician groups, podiatrists, and nonphysician medical
33 practitioners, shall be calculated and paid as follows:

34 (1) Except as provided under Section 14167.25, and only to the
35 extent that state funds are appropriated in the annual Budget Act,
36 commencing on July 1, 2010, reimbursement shall be established
37 at a percentage of the amount that the federal Medicare Program
38 would pay for the same physician service rendered on the same
39 date; provided, however, that such increased reimbursement shall
40 not exceed 100 percent of the amount that Medicare would pay.

1 This paragraph shall not reduce physician service rates currently
2 reimbursed at or above 100 percent of the Medicare reimbursement
3 rate or the rate that the department determines to be equivalent to
4 the Medicare rate pursuant to paragraph (3). In determining the
5 amounts to be paid pursuant to this paragraph, the department shall
6 ensure that the equivalent Medicare rate to be used takes into
7 account all of the factors, supplemental payments, and other
8 variables that are used to determine the Medicare rate.

9 (2) The supplemental rate augmentation paid for physician
10 services in California Children Services, as established in the
11 annual Budget Act, shall continue and be paid in addition to the
12 rate established in this section.

13 (3) Subject to the funding limitation set forth in paragraph (1),
14 the department shall establish a rate for physician services for
15 which Medicare does not provide a comparable physician service,
16 or for which the Medicare payment for the physician service cannot
17 be separately determined, which shall be the department's best
18 estimate of what Medicare would pay for that physician service,
19 to be set at the percentage established in paragraph (1).

20 (4) Physician services that are reimbursable under this section
21 may be provided in any service location, including in clinics, except
22 for hospitals when the hospital bills for the services, federally
23 qualified health centers, and rural health centers. Notwithstanding
24 the provisions of Section 14167.23, physicians, physician groups,
25 podiatrists, and nonphysician medical practitioners that provide
26 physician services in clinics shall not be required to be enrolled
27 as Medi-Cal providers in order for a clinic to receive
28 reimbursement for those services pursuant to this section.

29 (5) Claims for payment of services rendered by a nonphysician
30 medical practitioner, where the rate is established pursuant to this
31 section, shall comply with the provisions of subdivision (d) of
32 Section 51503.1 of Title 22 of the California Code of Regulations.

33 (c) As a condition of receiving reimbursement under this section,
34 a physician, physician group, clinic, podiatrist, or nonphysician
35 medical practitioner shall keep, maintain, and have readily
36 retrievable, any records specified by the department to fully
37 disclose reimbursement amounts to which the physician, physician
38 group, clinic, podiatrist, or nonphysician medical practitioner is
39 entitled, and any other records required by the federal Centers for
40 Medicare and Medicaid Services.

1 (d) This section shall apply to all services specified in this
2 section that are rendered to Medi-Cal beneficiaries on and after
3 July 1, 2010. With respect to all services that are paid under this
4 section, any other provider rate methodology that is inconsistent
5 or duplicative of the rates paid pursuant to this section shall become
6 inoperative for those services to the extent that the rates are
7 inconsistent or duplicative.

8 14167.25. (a) (1) Notwithstanding Section 14105 or any other
9 provision of law, on or after July 1, 2010, the director may
10 designate up to 25 percent of the rate increase paid to Medi-Cal
11 fee-for-service providers pursuant to subdivision (b) of Section
12 14167.24, to be directly linked to performance measures developed
13 pursuant to subdivisions (c) and (d), including a demonstrated
14 showing of continued performance improvement.

15 (2) For purposes of paragraph (1), the percentage of the rate
16 that is linked to performance measures shall be established by the
17 director such that physicians, physician groups, clinics, podiatrists,
18 and nonphysician medical practitioners will be sufficiently
19 reimbursed for implementing performance measures, including
20 continued performance improvement.

21 (b) The performance measures shall be developed by the
22 department in consultation with stakeholders, including, but not
23 limited to, representatives of patients, physicians, podiatrists,
24 nonphysician medical practitioners, managed care plans, payers,
25 and other appropriate stakeholders.

26 (c) The department, in consultation with the stakeholders
27 identified in subdivision (b), shall develop a comprehensive list
28 of performance measures relying, in part, on existing quality and
29 performance measures endorsed by national organizations, such
30 as the Ambulatory Quality Alliance, the Hospital Quality Alliance,
31 and the National Quality Forum.

32 (d) In developing the performance measures pursuant to
33 subdivision (c), the following performance measures may be taken
34 into consideration in determining the appropriate percentage rate
35 increases:

36 (1) Reporting of health care outcomes, including the cost of that
37 health care.

38 (2) Improvements in health care efficiency.

39 (3) Improvements in health care safety.

- 1 (4) The efficient exchange of health information data through
2 technology.
- 3 (5) The quality assurance requirements set forth in Section
4 1300.70 of Title 28 of the California Code of Regulations.
- 5 (6) Efforts to promote healthy behaviors among Medi-Cal
6 beneficiaries pursuant to the Healthy Incentives and Rewards
7 Program described in Section 14132.105.
- 8 (7) The extent to which purchasers, payers, providers, and
9 consumers are able to monitor the quality and cost of health care
10 utilizing public reporting information published by the Office of
11 the Patient Advocate.
- 12 (8) The extent to which physicians, physician groups, clinics,
13 podiatrists, and nonphysician medical practitioners that provide
14 services to Medi-Cal beneficiaries on a fee-for-service basis
15 implement activities, such as telemedicine, electronic prescribing
16 and the electronic exchange of health information among various
17 payers and providers for the purpose of attaining health care safety
18 and quality improvements, informed clinical care decisions, the
19 increased use of interoperable platforms for the exchange of
20 relevant health care data, and more accurate and timely diagnosis
21 and treatment.
- 22 (9) Compliance with the federal Health Insurance Portability
23 and Accountability Act (HIPAA) (42 U.S.C. Sec. 300gg).
- 24 (e) The department shall consult with stakeholders, including,
25 but not limited to, representatives of patients, physicians, managed
26 care plans, payers, and other appropriate stakeholders, to determine
27 the means to measure and document implementation by each
28 physician, physician group, clinic, podiatrist, and nonphysician
29 medical practitioner of the performance measures developed
30 pursuant to subdivisions (c) and (d).
- 31 (f) The department may exempt classes of physicians, physician
32 groups, clinics, podiatrists, and nonphysician medical practitioners
33 and specific services from this section, if necessary to comply with
34 the requirements of federal law or regulations.
- 35 (g) The department may file one or more state plan amendments
36 to implement this section.
- 37 (h) The department shall seek necessary federal approvals for
38 implementation of this section. The department shall implement
39 this section only in a manner that is consistent with federal
40 Medicaid law and regulations. This section shall be implemented

1 only to the extent that federal approval is obtained and federal
2 financial participation is available.

3 (i) The department shall implement this section only to the
4 extent that state funds are appropriated for the nonfederal share of
5 the rate increases provided under this section.

6 (j) The provisions of this section shall be implemented in such
7 a manner that they are appropriately integrated with the
8 pay-for-performance model described in subdivision (a) of Section
9 12803.2 of the Government Code.

10 SEC. 78. The State Department of Health Care Services, in
11 consultation with the Managed Risk Medical Insurance Board,
12 shall take all reasonable steps that are required to obtain the
13 maximum amount of federal funds and to support federal claiming
14 procedures in the administration of this act.

15 SEC. 80. Notwithstanding any other provision of law, the
16 Managed Risk Medical Insurance Board may implement the
17 provisions of this act expanding the Healthy Families Program
18 only to the extent that funds are appropriated for those purposes
19 in the annual Budget Act or in another statute.

20 SEC. 81. (a) In order to achieve the purposes of this act, the
21 State Department of Health Care Services, after consultation with
22 the Department of Finance, may utilize either state plan
23 amendments or waivers, or combination thereof, as necessary to
24 implement this act, to maximize the availability of federal financial
25 participation, and to maximize the number of persons for whom
26 that federal financial participation is available to cover the cost of
27 health care services.

28 (b) The flexibility authorized by this act shall include
29 modification of the requirements, standards, and methodologies
30 for expansion categories or populations created by this act in order
31 to maximize the availability of federal financial participation.
32 When exercising this flexibility, the State Department of Health
33 Care Services shall not make changes that would do any of the
34 following:

35 (1) Make otherwise eligible individuals ineligible for health
36 coverage under the Medi-Cal program and the Healthy Families
37 Program.

38 (2) Increase cost-sharing amounts beyond levels established in
39 this act.

40 (3) Reduce benefits below those provided for in this act.

1 (4) Otherwise disadvantage applicants or recipients in a way
2 not contemplated by this act.

3 (c) The department shall take all reasonable steps necessary to
4 maximize federal financial participation and to support federal
5 claiming in the implementation of this act.

6 (d) It is the intent of the Legislature that the provisions of this
7 act shall be implemented simultaneously to the extent possible in
8 order to harmonize and best effectuate the purposes and intent of
9 this act.

10 (e) The Director of Health Care Services shall notify the Chair
11 of the Joint Legislative Budget Committee in any case when it is
12 necessary to exercise the flexibility provided under this section.
13 This notification shall be provided 30 days prior to exercising that
14 flexibility.

15 SEC. 82. It is the intent of the Legislature that provisions of
16 this act shall be financed by contributions from employers;
17 individuals; federal, state, and local governments; and health care
18 providers. Specifically financial support shall include:

19 (a) Federal financial participation through the federal Medicaid
20 and S-CHIP programs.

21 (b) Revenue from counties to support the cost of enrolling
22 persons who would otherwise be entitled to county-funded care if
23 not for this act.

24 (c) Fees paid by acute care hospitals at a rate of 4 percent of
25 patient revenues.

26 (d) Fees paid by employers.

27 (e) Premium contributions from currently offering employers
28 when employees, eligible for employer-based coverage, choose
29 to enroll in public programs.

30 (f) Premium payments for individuals enrolled in publicly
31 subsidized coverage and coverage purchased in the individual
32 market.

33 (g) Additional public funds obtained through increasing the tax
34 on the sale of each package of cigarettes.

35 (h) Other state funds made available through savings generated
36 through reduced demand for existing health care programs.

37 SEC. 83. (a) Notwithstanding any other provision of this act,
38 the implementation of the provisions of this act other than this
39 section, including, but not limited to, the expansion of eligibility
40 for publicly funded or subsidized health care coverage, the increase

1 in the Medi-Cal program’s provider rates, the requirements
2 imposed on the offering and sale of health plan contracts or health
3 insurance policies in the state, and the requirement that individuals
4 enroll in and maintain health care coverage, shall be contingent
5 on a finding by the Director of Finance under subdivision (b) that
6 the financial resources necessary to implement those provisions
7 are available.

8 (b) Except as otherwise provided in subdivision (d), this act
9 shall become operative upon the date that the Director of Finance
10 files a finding with the Secretary of State that all of the following
11 circumstances exist:

12 (1) Based on reasonable financial projections, sufficient state
13 resources will exist in the Health Care Trust Fund to implement
14 the act. This determination shall be based on the projected amounts
15 of revenue that will be available to support the act and the projected
16 costs required by the act. These projections shall consider *and*
17 *include* the sufficiency of resources that will be available during
18 the first three years of operation under the act.

19 (2) The required federal approvals for program changes under
20 the act have been obtained or can reasonably be expected to be
21 obtained by the time those programs are implemented.

22 (3) Required federal resources will be available to implement
23 the act based on the anticipated schedule of review and approval
24 of state plan amendments and waivers applicable to the act.

25 (c) At least 90 days prior to filing the finding with the Secretary
26 of State, the Director of Finance shall transmit the finding described
27 in subdivision (b) to the Chief Clerk of the Assembly, the Secretary
28 of the Senate, and the chairs of the appropriate committees of the
29 Legislature.

30 (d) If any operative date specified in this act is later than the
31 date of the filing of the finding described in subdivision (b), that
32 later date shall apply.

33 (e) Nothing in this section shall be construed to prevent the
34 appropriation of funds for the support of the activities necessary
35 to prepare for the implementation of this act prior to the filing of
36 the finding described in subdivision (b).

37 *SEC. 83.5. It is the intent of the Legislature that credits against*
38 *employer contributions to finance Cal-CHIPP be for health*
39 *expenditures that do not discriminate on the basis of wage level*
40 *and that allow employees eligible for Cal-CHIPP or Medi-Cal to*

1 *choose to enroll in those programs by bringing the employer*
2 *contribution to the Cal-CHIP or the Medi-Cal program.*

3 SEC. 84. It is the intent of the Legislature that the state shall
4 develop and effectively implement a transition plan, by July 1,
5 2010, that will allow for payment of the premium and cost-sharing
6 burdens associated with insurance coverage with funding under
7 the federal Ryan White Comprehensive AIDS Resources
8 Emergency (CARE) Act of 1990 (42 U.S.C. Sec. 201) and other
9 funding.

10 SEC. 84.5. The Legislature finds and declares that each
11 provision of this act is an integral part of a comprehensive health
12 care reform effort and that no provision of this act is intended to
13 be severable from the remaining provisions. If any provision of
14 this act is held to be invalid, as determined by a final judgment of
15 a court of competent jurisdiction, the entire act shall become
16 inoperative, and those provisions of law amended by this act that
17 were in effect and operative immediately prior to the operative
18 date of this act shall again be operative.

19 SEC. 85. No reimbursement is required by this act pursuant to
20 Section 6 of Article XIII B of the California Constitution for certain
21 costs that may be incurred by a local agency or school district
22 because, in that regard, this act creates a new crime or infraction,
23 eliminates a crime or infraction, or changes the penalty for a crime
24 or infraction, within the meaning of Section 17556 of the
25 Government Code, or changes the definition of a crime within the
26 meaning of Section 6 of Article XIII B of the California
27 Constitution.

28 However, if the Commission on State Mandates determines that
29 this act contains other costs mandated by the state, reimbursement
30 to local agencies and school districts for those costs shall be made
31 pursuant to Part 7 (commencing with Section 17500) of Division
32 4 of Title 2 of the Government Code.

O